PATIENT REQUEST: RESTRICT PHI USE AND DISCLOSURE

Please check the appropriate box and fill in the blank as needed:

❐ ______________________________ (name of facility)

❐ All WellStar entities

Please complete the following section (print clearly):

Patient's Last Name, First Name, MI	Birth Date (Month / Day / Year)
Street Address / Apt # (include complete mailing address)	Medical Record Number (if known)
City State Zip	Home Phone # Alternate Phone #

DESCRIPTION OF THE PROTECTED HEALTH INFORMATION TO BE RESTRICTED:

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PERSON(S) OR ORGANIZATION(S) TO WHOM THE RESTRICTION APPLIES (if applicable):

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- I understand that if I request to restrict the disclosure of information to my health plan, I must pay for the services in full, out of my own pocket, at the time I receive the services.
- I understand that if my payment for these services is not honored (i.e. insufficient funds in my checking account to cover the check), then my insurance may be billed for the services.
- I understand that it is my responsibility to notify each of my providers, pharmacists, etc. of my restriction request and that WellStar is not responsible to notify any non-WellStar providers, pharmacists, etc. of my request.

PATIENT SIGNATURE:

____
Date of Request

____
Print Name

____
Signature of Patient Representative

____
Print Name of Authorized Personal Representative*

____
Signature of Authorized Personal Representative

* Please indicate your relationship to the patient:
❐ Parent or Guardian of an Unemancipated Minor
❐ Guardian or Conservator of an Incompetent Patient
❐ Medical Durable Power of Attorney
❐ Other ______________________________

For questions regarding a request to restrict the uses or disclosures of protected health information, please contact:
WellStar Health System, Attn: Chief Privacy Officer
793 Sawyer Rd.
Marietta, GA 30062
(O) 470-644-0444 / (F) 770-509-4236 privacyofficer@wellstar.org

WellStar Health System

***Patient Request:* Restrict PHI Use and Disclosure**