Restriction of Consent to Use and Disclosure of Protected Health Information

Restriction of Consent

This notice restricts the consent to use and disclosure of Protected Health Information for:

_____that was signed on:_____ *(Date of Consent).*

Name of Patient (print)

_____

Information to restrict

☐ I do not want my PHI *(Personal Health Information)* to be sent to my insurance carrier, I want to pay my provider out of pocket.

Effect of Restriction

Protected Health Information that is collected on or after the date on which this form is received by this office will no longer be used or disclosed by this office for the purposes of treatment or payment, or to support day-to-day health care operations of this office as described in the consent form.

This restriction of consent will not limit the ability of this office to seek payment for services that it provided under an earlier consent, including the consent specified above or to meet legal obligations related to those services, nor will it affect uses or disclosures that occurred prior to the effective date of this restriction.

It is the policy of this office, that it **will will not** continue to provide treatment for a patient who restricts consent to the use and disclosure of his or her Protected Health Information for the purposes of treatment, payment, or health care operations.

Effective Date of Restriction

This restriction of consent to use or disclose Protected Health Information is effective_____.

Signature

_____

Name of Patient (print)

_____

Signature of Patient **Date**

_____

Signature of Patient Representative **Date**

_____

Relationship of Patient Representative to Patient

_____

Office Representative **Date this form was received**