

Patient Label

UCI Health

REQUEST FOR SPECIAL RESTRICTION ON USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Date _____ Medical Record Number _____

Patient Name _____ DOB _____

I understand that UCI Health may use or disclose my protected health information (PHI) for the purposes of treatment, payment and health care operations. UCI Health may also disclose information to someone involved in my care or the payment for my care, such as a family member or friend, under certain circumstances.

I hereby request a special restriction on UCI Health's use or disclosure of protected health information.

The information I want limited is:

I want to limit:

- UCI Health's use of this information.
- UCI Health's disclosure of this information.
- Both the use and the disclosure of this information.

I want the limits to apply to the following person/entity (for example, a spouse):

I understand that UCI Health does not have to agree to my request, unless I am requesting a restriction on disclosure of information to a health plan for payment or health care operations purposes, and I have (or someone on my behalf other than the health plan has) paid for the item or service out of pocket in full. UCI Health will still be able to disclose this information to the health plan if required by law.

Even if UCI Health agrees to the restriction, it may share the information anyway in the following circumstances:

- During a medical emergency, if the restricted information is needed to provide emergency treatment. However, if the information is disclosed during an emergency, UCI Health will tell the recipient not to use or disclose it for any other purposes.
- Inclusion in UCI Health's directory.
- For certain public health activities.
- For reporting abuse, neglect, domestic violence or other crimes.
- For health agency oversight activities or law enforcement investigations.
- For judicial or administrative proceedings.
- For identifying decedents to coroners, medical examiners and funeral directors or determining a cause of death.
- For organ procurement.
- For certain research activities.

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- For workers' compensation programs.
- To avert a serious threat to health or safety.
- To the Secretary of Health and Human Services.
- For specialized government functions.
- For uses or disclosures otherwise required by law.

If a special restriction is agreed to, it may be terminated if:

- I request, or agree to, the termination in writing; or
- I orally agree to the termination and the oral agreement is documented; or
- The hospital informs me that it is terminating the agreement. In this case, the termination is only effective for PHI created by UCI Health or received by UCI Health after I am notified of the termination. UCI Health cannot terminate a special restriction on disclosure to a health plan for payment or health care operations purposes for items or services paid out of pocket in full, unless I agree.

Person completing form:

_____ Date: _____ Time: _____ AM/PM
Patient or Patient's Representative Signature

_____ Relationship to Patient Reason for Non-Patient Signature

If Interpreted: _____ Date: _____ Time: _____ AM/PM
ID# Language

Telephonic Video Interpreter

For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website at <http://www.ucirvinehealth.org/compliance> or at Compliance and Privacy Office at UCI Health or by sending a written request to:

UCI Health - Compliance and Privacy Office
333 City Blvd West, Suite 1610
Orange, CA 92868

If you believe your privacy rights have been violated, you may file a complaint with UCI Health or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with UCI Health, contact:

UCI Health - Compliance and Privacy Office
333 City Blvd West, Suite 1610
Orange, CA 92868

All complaints must be submitted in writing. You will not be penalized for filing a complaint.