



PATIENT REQUEST TO RESTRICT USES AND DISCLOSURES
OF PERSONAL HEALTH INFORMATION

I, _____, hereby request that the following restriction(s) be placed on the uses and disclosures of my personal health information by Jordan Hospital as detailed below.

Please give a full, specific description of the type of restrictions you are requesting regarding how and to whom your personal health information is used and disclosed. Restrictions may only be requested for those uses and disclosures that relate to your treatment, your payment or insurance, or the business operations of Jordan Hospital.

Restriction(s) Requested :

Three horizontal lines for writing the requested restrictions.

I understand that Jordan Hospital is not required to agree to my restriction requests, but that Jordan Hospital is only required to attempt to accommodate reasonable requests when appropriate. I further understand that Jordan Hospital reserves the right to terminate an agreed-to restriction if it feels that termination is appropriate, and that I also have the right to terminate, in writing, any restriction by sending a termination notice to Jordan Hospital, Director of Health Information Services, 275 Sandwich Street, Plymouth, Massachusetts 02360.

Patient Name

Name of personal representative, if applicable

Relationship of personal representative to patient

Signature of patient (or patient's representative) Date

For Organizational Use Only:

Name/title of staff member who received this form: _____

Date form received: _____ Restriction: _____ Approved _____ Denied

Authorized Hospital Representative Date