REQUEST TO RESTRICT USES AND DISCLOSURES OF PERSONAL HEALTH INFOMATION (PHI)

PATIENT INFORMATION

Name_____ Date of Birth _____/_____/ _____

Street Address_____

City _____ State _____ Zip _____

Phone _____ E-mail Address _____

I hereby request that the following restriction(s) be placed on the uses and disclosures of my personal health infomation by The Ohio State University College of Optometry.

_____ Exam and test records _____ Financial records

LIST OF RESTRICTIONS REQUESTED

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 The Ohio State University College of Optometry. (For example, you may request that we restrict the use of your information for disease management purposes.)

I understand that The Ohio State University College of Optometry is not required to agree to my restriction requests, but that The Ohio State University College of Optometry may only be required to attempt to accommodate reasonable requests when appropriate. I further understand that The Ohio State University College of Optometry 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 the HIPAA Privacy Officer at the address at the bottom of this form.

_____ _____

Signature **Date**

Please note that will will not process any requests that are not signed by you or your personal representative.

Return this form to the HIPAA Privacy Officer, The Ohio State University College of Optometry, 338 West Tenth Avenue, Columbus, OH 43210, 614-292-2020.