Patient PHI Restriction Request

You have the right to request that we restrict our use and disclosure of your Protected Health Information (PHI). While we are not required to agree to your request for a restriction, will do our best to accommodate all reasonable requests.

Please complete the below information (any section that is left blank may delay our response to your request)

Patient Name (Print): ______________________________________ DOB: _______________________

Phone (home or mobile): _________________________ Date of Request: ______________

Restricted Person/Entity (select one):

□ Person (print name and relationship): ____________________

□ *Health Plan (print name): ____________________

***Health Plan restrictions must be coordinated with the Privacy Officer *prior* to services being rendered. We will accommodate requests to restrict PHI from Health Plans under the following circumstances:

1. The disclosure to the Health Plan is not required by law
2. The PHI pertains solely to a health care service that you have paid for in full at time of service.

Restricted PHI (select one):

□ All PHI
□ Specified PHI (list only the specific PHI to be restricted)

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I understand that any restrictions agreed to by this office does not apply to use or disclosure of my PHI by this office for emergency medical care or as otherwise provided by law.

All requests for the PHI Restrictions should be documented in writing and directed to the AKDHC/PKDHC Privacy Officer. Completed request forms should be mailed to the Privacy Office using the contact information below or handed to the office staff who will direct the request to the Privacy Office for you.

AKDHC Administration Attn: Privacy Officer
3333 East Camelback RD Suite 180
Phoenix, AZ 85018

Phone: 602-997-0484

____________________ ____________________
Patient or Legal Representative **Printed** Name Patient or Legal Representative **Signature**

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Date

OFFICE USE ONLY:			
Request Received By:		Date:	