AFFILIATES IN INTERNAL MEDICINE

REQUEST FOR AUTHORIZATION/RESTRICTION ON USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Instructions:
You may request authorization on our use and disclosure of your protected health information (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend of any other person identified by you) involved with your care or with payment related to your care, (3) to notify or assist in the notification of such individuals regarding your location and general condition; and (4) to your health insurers/payors for payment or health care operation purposes where the disclosure relates solely to a health care item(s) or service(s) that you or your representative will pay the facility, in full and out of pocket, for, unless such disclosure would be required by law.

If you are requesting the restriction on disclosure of your protected health information to your insurance company for one or move date of service, you are responsible for paying the applicable bill in full for such services. If you wish to request restrictions, please REQUEST the 2nd page of this form. While we will consider all requests for restrictions carefully, we are not required to agree to a requested restriction(s) unless you have requested a restriction to your health insurers/payors for payment or health care operations purposes as described in (4) above.

Emergency Treatment exception: If the facility agrees to a restriction request or a portion thereof, HIPAA privacy regulations provide an exception in emergency treatment situations for a hospital or provider to use and disclose necessary information to treat the patient.

Patient's Legal Name (First, Middle, Last)____

Patient's Date of Birth____

Please check and initial the appropriate box:

☐ ______ **Initials** ***(1)*** *for treatment, payment and health care operations*

☐ ______ **Initials** ***(2)*** ***release to individuals (such as a family member, other relative, close personal friend of any other person identified by you) involved with your care or with payment related to your care***

Name:____________________________________ ***Relationship to patient:***___________________

Name:____________________________________ ***Relationship to patient:***___________________

Name:____________________________________ ***Relationship to patient:***___________________

☐ ______ **Initials** ***(3)*** *to notify or assist in the notification of such individuals regarding your location and general condition*

☐ ______ **Initials** ***(4)*** *to your health insurers/payors for payment or health care operation out of pocket, for, unless such disclosure would be required by law.*
If the bill is not paid in full by the patient within 60 days of service, then the restriction no longer applies and the information will be disclosed to your insurance carrier on file for reimbursement. If the carrier denies the claim for any reason, you will remain responsible for payment in full. If payment is not received your account may be forwarded to a collection agency.

Signature of Patient_______________________________________ Date________________________