Request for Restriction on Use and Disclosure of Protected Health Information

NOTE: Sections A, B & C of this form must be completed in full (Please Print). Incomplete forms may delay processing your request.

SECTION A: Patient Information	
Patient Name:	Current Address:
Date of Birth:	City:
Phone Number:	State, Zip:

	SECTION B: This restriction request applies to (check box on left and provide additional information accordingly):
☐	I do not authorize the use and/or disclosure of my PHI to the following person or entity (provide name of person & relationship, or entity name):
☐	I am requesting my insurance company is not provided clinical information or billed for services related to date of service: _____. I accept financial responsibility and have paid in full the out-of-pocket expense(s). (Provide the name of the health plan and the subscriber number):
	ALSO COMPLETE THE FOLLOWING FOR ALL REQUESTS:
	I am requesting the following specific health information be restricted from the person(s) or entity stated above (include dates of service(s), where applicable). (Note: Date of service and the service/procedure you wish to restrict from disclosure must be provided if the request is to restrict this health information from your health plan):
	Explain the Reason for this Restriction Request (optional):

SECTION C: Understanding Your Right to Request a Restriction and Our Obligations:

I understand that I have the right to request restrictions on the ways in which Cascade Nutrition Consulting uses and/or discloses my health information. Cascade Nutrition Consulting will carefully consider my request but is not required to grant my request. I understand that I will receive a written determination regarding my request. If Cascade Nutrition Consulting grants my restriction request, my information may still be shared during a medical emergency or as required by federal and/or state laws. In addition, if my request is granted, I understand that I may end the restriction at any time by giving written notice to Cascade Nutrition Consulting Privacy Office.

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If my request is to restrict disclosure to my health plan for a service for which I have paid out-of-pocket, I understand that any pending balance must be paid at the time of service. I also understand that I must communicate my request for restriction from my health plan to all other healthcare providers for services rendered outside of the single service for which I have made a payment pursuant to this restriction request.

Patient/Legal Representative Signature: _____ Date: _____

Legal Representative Name: _____ Relationship: _____

Please send this form to Cascade Nutrition Consulting
2660 NE Highway 20 Suite 610-26
Bend, OR 97701

Or fax to: 541-385-4987

The Privacy Office will respond to the patient in writing either granting or denying the request.

Section D: Internal Use Only	
Date request Received:	Reason for Denial (if applicable):
Request (Privacy Office use only): Granted ☐ Denied ☐	
Date Response sent to patient/personal representative:	