

# Patient Request for PHI Restriction



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, we 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)  
\_\_\_\_\_  
\_\_\_\_\_

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 NKDHC 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.

NKDHC Administration Attn: Privacy Officer  
2545 S Bruce ST Suite 200  
Las Vegas, NV 89169  
Phone: 702-732-2438

\_\_\_\_\_  
Patient or Legal Representative **Printed** Name

\_\_\_\_\_  
Patient or Legal Representative **Signature**

\_\_\_\_\_  
Date

OFFICE USE ONLY:			
Request Received By:		Date:	