

# Patient Request to Revoke PHI Restriction



You have the right to revoke a Protected Health Information Restriction that has been agreed to by NKDHC. By completing this form, you are documenting that you would like to revoke a current restriction that is in place.

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:* Any restriction in place for a Health Plan only relates to the specific services provided that were paid for by you in full at time of service.

All requests for the revocation of a PHI Restriction 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

I hereby revoke the above restriction.

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

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

\_\_\_\_\_  
Date

| OFFICE USE ONLY:     |  |       |  |
|----------------------|--|-------|--|
| Request Received By: |  | Date: |  |