SPECTRUM HEALTH

Authorization REQUEST FOR RESTRICTION OF USE/ DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name

DOB

MRN

Physician

FIN

PATIENT TO COMPLETE

Patient name _____

Date of birth _____

Address _____ Phone (_____) _____

_____ (_____) _____

Email _____

Request date _____

Indicate your request for restrictions to the uses and disclosures of your protected health information:

_____

_____

_____

_____

_____

_____

FROM SPECTRUM HEALTH

As our patient, you have the right to request that we restrict our use and disclosure of your protected health information. Although the law does not require us to agree to your requested restriction(s) we will honor your request to the ***best of our ability*** or notify you in writing that we are unable to honor your request.

BELOW ARE INSTANCES IN WHICH WE WILL BE UNABLE TO HONOR YOUR REQUEST FOR RESTRICTION:

- During a medical emergency if the restricted information is needed to provide emergency treatment
- Certain public health activities such as to prevent or control disease, injury or disability
- Reporting abuse, neglect, domestic violence, or other crimes
- For health agency oversight activities such as auditing, investigations, inspections, and expenditures
- For law enforcement investigations regarding the investigation of criminal activity
- For judicial or administrative proceedings in response to a subpoena, court order, or other similar process
- For identifying decedents to coroner and medical examiners or determining cause of death
- For organ procurement
- For research activities
- For workers' compensation programs
- For uses or disclosures otherwise required by law
- For payment of services provided unless payment for such services has been rendered and accepted as payment in full

ALTERNATIVE METHOD OF COMMUNICATIONS

We will accommodate your reasonable written request to receive communications of medical information by alternative means of alternative location only if you: 1) specify the alternative location, address, or telephone number and/or the alternative means of contact AND 2) agree to be responsible for and explain how payment will be handled for any additional cost associated with the alternative method of communication.

OVER ➔

DO NOT MARK BELOW THIS LINE BARCODE ZONE DO NOT MARK BELOW THIS LINE

* X 1 1 9 3 1 *

PATIENT AUTHORIZATION

Time Date Patient Signature **TIME DATE** Witness to Signature

If a patient is under 18 years of age or otherwise unable to consent, the following must be completed:

I,_____, hereby certify that I am the _____

of the patient; that patient is unable to consent because patient is a minor, or because:

_____

Time Date Signature of Parent, Legal Guardian, Patient Advocate or Next of Kin **TIME DATE** Witness to Signature

A COPY OF MY PERSONAL REPRESENTATIVE FORM OR LEGAL DOCUMENT: *(check one)*

☐ Is on file
☐ Is attached

I MUST:

- **Keep a copy of this request form for my records.**

SPECTRUM HEALTH STAFF

Send this completed request form to Spectrum Health's Health Information Management Department for review and approval/denial.

If Spectrum Health Medical Group, send to Health Information Management (HIM) manager below. For questions, call HIM manager at 616.485.3718.

- Mail code: 063
- Fax: 616.391.1521
- Mail: Spectrum Health Medical Group, HIM manager, 100 Michigan St. NE, Grand Rapids, MI 49503

If Spectrum Health System (Hospitals), send to Health Information Management (HIM) supervisor below. For questions, call HIM supervisor at 616.643.9002.

- Mail code: 063
- Fax: 616.391.1521
- Mail: Spectrum Health, HIM, Release of Information Manager 100 Michigan St. NE, Grand Rapids, MI 49503

HIM STAFF USE ONLY

Date request received _____

DETERMINATION OF REQUEST

☐ Approved
☐ Denied Reason denied _____

PATIENT INFORMED OF DETERMINATION

By whom: Time _____ Date _____ Staff signature _____
By what means: ☐ Phone ☐ Other _____
When: Time _____ Date _____

HIM CHECKLIST

☐ Scan authorization into electronic medical record (EMR)
☐ Paper record updated
☐ EMR updated (EPIC patient FYI)

TIME _____ **DATE** _____ Health Information Management signature _____