Request for Restrictions on Uses and Disclosures

This form is used for an Individual to request HealthTrust not use or disclose their protected health information (PHI). Individuals have the right to request restrictions on how their PHI is used or disclosed for treatment, payment, or health care operations. They also have the right to request restrictions on notifying or disclosing information to family Individuals, friends, or others involved in their care. (45 CFR § 164.522 (a)).

I request to restrict use and disclosure of protected health information concerning health care treatment, payment or health care operations about me. (Please complete one (1) through three (3) below. If not applicable, mark N/A in the box. Please use the back of this form if additional space is required).

1	I request the following information be restricted:
2	I request that use and disclosure of the above described information be restricted in the following manner:
3	I request that my protected health information not be disclosed to the following individuals or entities:

By signing this form,

- I understand that HealthTrust may use and disclose protected health information about me for purposes of health care treatment, payment and health care operations without my consent.
- I understand that HealthTrust is not required to agree to this restriction.
- I understand that if HealthTrust agrees to this restriction, either HealthTrust or I may terminate this restriction at any time, if the request to terminate is made in writing. The termination of the restriction is only effective for future uses and disclosures.
- I understand that if protected health information must be used or disclosed to provide emergency treatment for me, then this restriction is void.
- I understand that if a restriction is not specifically listed above and agreed to in writing by HealthTrust it will not be effective.

Your Name (printed):	Your Contact Information (Address, Phone, Email):
Your Signature:	Date:

If a legal representative signs on behalf of the individual, a copy of the legal representative's authority must be attached to this form, e.g. Health Care Power of Attorney, Executor/Administrator of an estate.

TO BE COMPLETED BY HEALTHTRUST WORKFORCE MEMBER Reference: HIPAA Individual Rights Policy.	
Name of HealthTrust Workforce Member Receiving Form:	Date: