Request for Restriction on Use and Disclosure of Patient Information

I hereby request the following restrictions for use and disclosure of patient information contained in medical records or billing records maintained by Harris County Hospital District.

Restriction Request:

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Harris County Hospital District is not required to accept your request. However, if we do, we will comply with your request unless the information is needed to provide you with emergency treatment. If we can no longer comply with the request, we will notify you in writing of the termination of the agreed to restriction.

Signature____ Date ______________________

Printed Name ____

Relationship if not Patient ____

Personal Representative's Address
(if applicable)

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Acceptance/Denial Response
For Harris County Hospital District Use Only:

The above request has been **accepted/denied** (circle one).

Your request for restrictions has been denied for the following reason/s:

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[Signature of Privacy Officer or Designee] [Date]

282020(06/03)