

**PINE CREEK MEDICAL CENTER  
REQUEST FOR RESTRICTIONS ON USE AND DISCLOSURE OF  
PROTECTED HEALTH INFORMATION**

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ SSN \_\_\_\_\_  
\_\_\_\_\_ Phone \_\_\_\_\_

I understand that (name of entity) \_\_\_\_\_ (“Hospital”) may use or disclose my Protected Health Information for treatment, payment, or health care operation purposes (“TPO Purposes”) or for other purposes related to my care, including communication with a family member or close friend for treatment, payment, notification purposes, including identification and location purposes, or for disaster relief purposes (“Special Purpose”). “Protected Health Information” means health information that identifies me or can be used to ascertain my identity and which is maintained by Pine Creek and/or transferred to another entity in either written or electronic form. I also understand that I have the right to request (“the Request”) that Pine Creek Medical Center NOT disclose certain aspects of my Protected Health Information (the “Restricted Information”). I understand that Pine Creeks' decision with regard to this Request is completely discretionary and Pine Creek IS NOT REQUIRED to agree to any Request. I understand that if Pine Creek agrees to the Request (the Agreement”), then Pine Creek Medical Center will not be permitted to use or disclose the Restricted Information in violation of the Agreement. I understand that even if Pine Creek agree to the request, there may be circumstances in which the hospital will be permitted or required by law to use or disclose the Restricted Information, including but not limited to, for my own emergency treatment, for law enforcement purposes, public health activities, health oversight activities and certain purposes.

I hereby request Pine Creek Medical Center NOT use or disclose the following Restricted Information for TPO Purposes or Special Purposes. *(Please be specific):*

\_\_\_\_\_

**NOTE: Hospital will**

**continue to use or disclose your Protected Health Information until the hospital makes a determination of whether to agree or not to agree to the Request. You will be notified via regular mail of such determination.**

*Signature* \_\_\_\_\_

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**FOR HOSPITAL USE ONLY**

HOSPITAL HEREBY:     AGREES     DOES NOT AGREE TO THIRD REQUEST.

IF HOSPITAL DOES NOT AGREE, PLEASE PROVIDE AN EXPLANATION:

\_\_\_\_\_

\_\_\_\_\_

*Signature* \_\_\_\_\_                      *Print Name* \_\_\_\_\_

*Title* \_\_\_\_\_                                      *Date* \_\_\_\_\_