OneCore Health
Open MRI

REQUEST FOR CONFIDENTIAL COMMUNICATION AND LIMITED USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

NOTICE: The Health Insurance Portability and Accountability Act pf 1996 (HIPAA) allows you to request that we communicate with you about your PHI in a way that is confidential. Please use this form to describe the limitations on use and disclosure that you are requesting. As stated in the law, we are not required to honor your request. If we agree to honor your request, we will comply with your request unless the information is needed to provide emergency treatment, payments, operations, and if legally required by applicable federal or state laws.

Patient Name_____

Birth Date_____ SS#_____

PATIENT REQUEST FOR RESTRICTIONS (MUST CHOOSE ONE)

Please check the applicable section, fill in requested details, and sign and date at the bottom.

☐ **SPECIFIC RECEIVERS**

Other than your physician(s), list people you would like to have permission to receive your protected health information.

_____, _____, _____, _____

☐ **PROHIBIT ALL RECEIVERS**

If this line is checked, I request that you do not disclose any of my PHI to anyone including family and friends, excluding information and disclosures necessary for treatment, payment and health care operations.

I certify that I am over 18 years of age and acknowledge that an explanation has been provided to me of how my PHI is used and disclosed. I understand that I may change this limitation of use and disclosure at a future time. I also understand that I am responsible for providing the correct contact information, or if later changed, I will report the change.

Signature of Person Submitting Request_____ Date_____

