



# NORTHERN INYO HOSPITAL

Northern Inyo County Local Hospital District

150 Pioneer Lane · Bishop, California 93514 · Voice (760) 873-5811 · Fax (760) 872-2768

## PATIENT INFORMATION RESTRICTION REQUEST

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Medical Record No.: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I understand that Northern Inyo Hospital may use or disclose my protected health information for treatment, payment and hospital operations purposes. The hospital may also disclose information to someone involved in my care or the payment of my care, such as a family member or friend. I want to request a restriction on the hospital's use or disclosure of protected health information about me. I understand that the hospital does not have to agree to this request. The information I want to restrict is:

Person(s):	Information:

I understand that Northern Inyo Hospital will provide me with a **written response** to this request for restrictions, after review by the hospital Administrator. The review process may be completed within 24 hours, but may take longer, up to several days. I further understand that in the event that the hospital agrees to my request, the restrictions will not be effective until the date and time that the hospital agrees in writing to my request for restrictions. During the review process, our staff may make reasonable efforts to comply with a reasonable restriction request.

Even if the hospital agrees to this restriction, it may continue to use and disclose the information in the following circumstances:

- During a medical emergency if the information is needed to provide emergency treatment. The hospital will, however, tell the recipient of the information not to use or disclose it for any other purposes.
- For inclusion in our hospital directories, unless otherwise restricted in writing on a "Request to Withhold Directory Information from the Public" form.
- For reporting purposes when we are not required to obtain your authorization nor give you the opportunity to disagree, such as public health, law enforcement, abuse, neglect and domestic violence, coroner, organ procurement, and workers' compensation reporting and to the Secretary of HHS, when required.

If this restriction is agreed to by the hospital, it may be terminated if:

- I request, or agree to, the termination in writing
- I orally agree to the termination and the oral agreement is documented
- The hospital informs me that it is terminating the agreement. In this case, the termination is only effective for information created or received by the hospital after I am notified of the termination.

Signature of patient or representative

Date/Time

If signed by other than patient, indicate relationship: \_\_\_\_\_

### FOR HOSPITAL USE ONLY

Received by:

Date/Time