

**SOUTHEAST MISSOURI STATE UNIVERSITY**

*Please check the appropriate Health Care Component*

Self-funded Health Plan

Health Clinic

Autism Center

**REQUEST FOR RESTRICTION OF USE AND DISCLOSURE  
OR REVOCATION OF AUTHORIZATION**

1. I, \_\_\_\_\_ hereby [please initial all that apply]:  
 \_\_\_\_\_ revoke the Authorization to use or disclose protected health information related to \_\_\_\_\_  
 \_\_\_\_\_ dated \_\_\_\_\_ [Sign and return below].  
 \_\_\_\_\_ request a restriction on the **use** of the protected health information related to \_\_\_\_\_  
 \_\_\_\_\_. [Proceed to question 2.]  
 \_\_\_\_\_ request a restriction on the **disclosure** of the protected health information related to \_\_\_\_\_  
 \_\_\_\_\_. [Proceed to question 3]
2. Complete this question 2 only if you are requesting a limitation on the **use** of your protected health information.
  - a. I wish to limit the use of the following protected health information [please specifically describe the information you wish to restrict, including the date of the service, the treatment rendered and the type of record]:
  - b. I request that the above listed protected health information not be used for the following purpose(s):
3. Complete this question 3 only if you are requesting a limitation on the **disclosure** of your protected health information.
  - a. I wish to limit the disclosure of the following protected health information [please specifically describe the information you wish to restrict, including the date of the service, the treatment rendered and the type of record]:
  - b. I request that the above listed protected health information not be disclosed to the following individuals and/or entities [please provide the name of the individual or entity and his/her/its relationship to you]:
4. Circle question 4 if you have paid out of pocket for a health care item or service and you wish to limit disclosure to your health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment), except as otherwise required by law.

Dated: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority

**FOR OFFICE USE ONLY**  
The Covered Entity hereby:

\_\_\_\_\_ agrees to the requested restriction.  
\_\_\_\_\_ does not agree to the restriction (does not apply to question 4).

\_\_\_\_\_  
Dated

\_\_\_\_\_  
Signature