

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