I understand that I have the right to request restrictions and request revocation of restrictions on how Northwest Community Hospital (NCH) and Northwest Community Day Surgery Center (DSC) may use or disclose my protected health information (PHI) to carry out treatment, payment or health care operations. I also understand that the law does not require NCH/DSC to agree to my request(s). However, if NCH/DSC agrees to any restrictions, then NCH/DSC shall be legally bound to abide by such restrictions, except for uses and disclosures to a health care provider in the event that I need emergency treatment (in which case NCH/DSC will request that the provider not re-disclose the information) or when such uses or disclosures is required or otherwise permitted under law.

Patient should initial one of the following:

_____ I request the following restrictions on my PHI.

_____

_____

Final disposition (to be completed by Privacy Official)

_____

_____

_____

By signing below, I acknowledge and affirm all of the statements above.

_____

Signature of patient/personal representative

_____

Printed name of patient/personal representative

Date

If personal representative, indicate relationship: _____

_____

Signature of NCH Privacy Official indicates agreement with individual's requested restriction(s) *Date*

_____ I request that the above noted restrictions be revoked.

FINAL DISPOSITION (to be completed by Privacy Official):

_____

_____

_____

By signing below, I acknowledge and affirm all of the statements above.

_____

Signature of patient/personal representative

_____

Printed name of patient/personal representative

_____

Date

If personal representative, indicate relationship: _____

_____

Signature of NCH Privacy Official indicates agreement with individual's requested restriction(s) *Date*