UTRGV UT Health Rio Grande Valley	Category: HIPAA Privacy Manual Policy Number: 15.010A Effective Date: April 10, 2024 Last Reviewed: April 1, 2024 Page 1 of 2
Title: Request for Restrictions on Use or Disclosure	
Reference: 45 C.F.R. §§ 160.202, 164.504(e)(2)(ii)(F), 164.504(f)(2)(ii)(F),	

REQUEST FOR RESTRICTIONS ON USE OR DISCLOSURE

It is our policy to not grant restrictions on uses or disclosures of protected health information for treatment for our own administrative and quality review procedures.

Patient's Name: _____

1. Information to be Restricted:

   _____

   _____

2. Restrictions on Use or Disclosure:

   _____

   _____

3. Agreement: I understand that
   a. My request will be considered and may be accepted or rejected.
   b. I will be notified of the decision to accept or reject my request.
   c. If I request restrictions on the use or disclosure of the information for payment purposes, I am responsible for payment of the bill in full and will be expected to make payment toward the total bill in advance of services provided.
   d. Use or disclosures that have already occurred prior to my restriction request are not covered by this request, if the request should be granted.

_____ _____ _____

Signature Printed Name Date

Phone Number: _____

Address _____

If Patient's personal representative, state relationship and authority: _____