Cleveland Clinic

Cleveland Clinic Health System
Request for Restriction on Use and Disclosure of Protected Health Information

NOTE: Sections A, B & C of this form must be completed in full (Please Print). Incomplete form may delay processing your request.

SECTION A: Patient Information:	
Patient Name	Cleveland Clinic Medical Record #
Current Address	City State Zip
Last 4 of Social Security Number	Phone Number ( ) Date of Birth / /
Location of Medical Appointment	

	SECTION B: This restriction request applies to (check box on left and provide additional information accordingly):
☐	I do not authorize the use and/or disclosure of my PHI to the following person or entity (provide name of person & relationship, or entity name):
☐	I am requesting my insurance company is not provided clinical information or billed for services related to the _____ date of service. I accept financial responsibility and have paid in full the out of pocket expense(s). (*provide the name of the health plan and the subscriber number)*:
	ALSO COMPLETE THE FOLLOWING FOR ALL REQUESTS:
	I am requesting the following specific health information be restricted from the person(s) or entity stated above (include dates of service(s), where applicable). *(Note: Date of service and the service/procedure you wish to restrict from disclosure must be provided if the request is to restrict this health information from your health plan)*: _____ _____
	Explain the Reason for this Restriction Request (optional): _____ _____

SECTION C Understanding Your Right to Request a Restriction and Our Obligations :

I understand that I have the right to request restrictions on the ways in which Cleveland Clinic uses and/or discloses my health information. Cleveland Clinic will carefully consider my request but is not required to grant my request. I understand that I will receive a written determination regarding my request. If Cleveland Clinic grants my restriction request, my information may still be shared during a medical emergency or as required by federal and/or state laws. In addition, if my request is granted, I understand that I may end the restriction at any time by giving written notice to the Cleveland Clinic Health System Privacy Office.

If my request is to restrict disclosure to my health plan for a service for which I have paid out-of-pocket, I understand that any pending balance must be paid within 30 days of the date of service. I understand that if

Cleveland Clinic is unable to obtain payment of any pending balance, as noted herein, or any other non-payment (i.e. payment declined, made invalid), then Cleveland Clinic is permitted to bill my health plan for the services provided. I also understand that I must communicate my request for restriction from my health plan to all other healthcare providers for services rendered outside of the single service for which I have made a payment pursuant to this restriction request, including but not limited to, lab tests, follow-up care, radiology services, and pharmacy services.

Patient/Legal Representative Signature: _____ Date:_____

Legal Representative Name : _____ Relationship : _____

Please send this form to the Cleveland Clinic Health System Privacy Office
The Privacy Office / DD2-20, The Cleveland Clinic Foundation
9500 Euclid Avenue, Cleveland, OH 44195 or fax to 216-445-8144

The Privacy Office will respond to the patient in writing either granting or denying the request.

SECTION D: Internal Use (for Cleveland Clinic caregivers only):	
Date Request Received:	Reason for Denial (if applicable):
Request (Privacy Office use only): Granted ☐ Denied ☐	
Date Response sent to patient/personal representative:	☐ Restriction applied in EPIC, if applicable
Name of Cleveland Clinic caregiver who processed this request:	
Estimated Amount:	
Amount Paid:	Date Paid: