Request for Restrictions on
Uses or Disclosures of Protected Health Information to a Health Plan
for Services Paid in Full Out of Pocket

Washington University will accept for review written requests for certain restrictions on its Use and Disclosures of your Protected Health Information ("PHI") including restrictions on Uses or Disclosures for Treatment, Payment, and Health Care Operations and restrictions on Disclosures to persons involved in your care, such as family or friends. Washington University is not required under federal or state law to agree to abide by any requested restriction except we must agree to your request to restrict disclosure of your health information to your health plan in the disclosure is not required by law and the health information you want restricted pertains solely to a health care item or service for which you (or someone other than your health plan, on your behalf) have paid us for in full at the time the service was provided.

In accordance with federal regulations, requests for restrictions will also not affect Washington University's Use or Disclosure of PHI in certain circumstances such as disclosures for public health activities, to report victims of abuse, neglect or other violence, to the federal or state health departments, or for law enforcement or judicial purposes.

Request Date: _______________

Individual Name: ____

Date of Birth: ________________ SSN: __________________________

Individual Address:____

Telephone Number: (H)______________________ W)_________________________

Self Pay Restriction Request

1. I hereby request a restriction on the disclosure of my health information by Washington University to my health plan related to the service or item described below. I have paid out of pocket in full and will not use my insurance coverage to pay for any portion of this service or item.

   Date of Service: ________________ Provider(s): ________________

   Service or item: ____

   Name of Health Plan: ____

2. I understand that if I am requesting a restriction to my health plan I am required to pay for the service out of pocket in full before or at the time the service or item is provided. ______(initial)

3. I understand that this form only covers services billed by Washington University Physicians and that it is my responsibility to request this same restriction from other providers who may be involved in my care for this service (e.g., Radiology, Pharmacy, Lab/Pathology, Hospital) to ensure they do not send my PHI to my insurance company.________(initial)

4. I understand that even if my requested restriction is accepted, Washington University may use or disclose restricted information if such information is necessary to provide me with emergency treatment.________(initial)

5. During future visits to Washington University Medical Center or our affiliated practices, other providers may reference this restricted visit in their notes and that those documents may be sent to my insurance provider to justify payment for those future visits. Washington University Physicians will not redact or alter those notes to reflect this restriction request. ___________(initial)
6. This restriction covers this and only this particular visit, and that if follow-up care is needed that I want restricted, I will need to fill out another form to cover each one of those visits.__________(initial)

7. I understand that Washington University may terminate an agreed upon restriction, in which case the termination is effective only with respect to PHI created or received after the date that Washington University notifies me of the termination. I further understand that I may terminate an agreed upon restriction orally or in writing.________(initial)

____

Signature of Individual or Personal Representative Date

For Washington University Use Only:

Date of Response:__________________

_______ Restriction Agreed Upon ______ HIPAA Office & PBS notified

_______ Restriction Denied

Signature of Staff Person _______________________________ Date _____________

Print Name & Title____