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|--------------|-----|-----|--------|
| Patient name | | | |
| MHN | DOB | Age | Gender |

Restrictions by Patient**Release of Information Request**

Request date (month/day/year) _____ / _____ / _____

Patient address _____

City _____ State _____ ZIP _____

What needs to be restricted

Explain how you wish us to restrict uses or disclosures of your health information to carry out treatment, payment or health care operations.

Explain how you wish us to restrict disclosures of your health information to:

- your family member or other person identified by you as being involved in your care or payment for your care
- a person or organization for disaster relief purposes

I understand that Marshfield Clinic Health System is not required to agree to my request to restrict uses and disclosures of my health information.

Patient signature (Patient's legal representative signature) _____ (Relationship to patient) _____ / _____ / _____ Signature date (m/d/y) _____ Phone number

Send completed request to: Release of Information, Marshfield Clinic Health System, 1000 N. Oak Ave., Marshfield, WI 54449
Fax: 715-221-6992 E-mail: medicalrecords@marshfieldclinic.org

FOR MARSHFIELD CLINIC HEALTH SYSTEM INTERNAL USE ONLY

Date received (m/d/y) _____ / _____ / _____

 Accepted Denied

If denied, check reason for denial:

- PHI was not created by Marshfield Clinic Health System
- PHI cannot be restricted for quality and continuity of care reasons
- Request is for restriction of uses or disclosures of PHI for purposes other than treatment, payment or health care operations
- Request is for restriction of disclosures of PHI for other than 164.510(b) purposes

Comments: Individual was informed of denial in writing (attach letter of communication)

Staff member signature/title _____ Date (month/day/year)