INDIVIDUAL REQUEST TO RESTRICT THE USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

Policy No.: ________________________

Insured Name: ___________________________________________ Insured Birth Date: ________________

Address: ________________________________________________________________________________

SSN: __________________________________________

I wish to have American Community restrict the use and disclosure of my protected health information as follows:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

_______________________________________________ _________________________________
Signature Today's Date

PLEASE NOTE: American Community is not required to honor an agreed upon restriction in the following situation(s):

(1) when the individual who requested the restriction is in need of emergency treatment and the restricted protected health information is need to provide the emergency treatment; and
(2) if restricted protected health information is disclosed to a health care provider for emergency treatment, American Community will request that such health care provider not further use or disclose the information.

American Community may terminate its agreement to a restriction in the following situations:

(1) the individual agrees to or requests the termination in writing;
(2) the individual orally agrees to the termination and the oral agreement is documented; and
(3) American Community informs the individual that it is terminating its agreement to a restriction. Such termination is only effective with respect to protected health information created or received after it has so informed the individual.

**FOR AMERICAN COMMUNITY USE**: Date this request was received ___________________

Status: ___ Accepted ___Denied

If denied, reason for denial _________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Response to Request sent: ______________________

Name of Staff Member: _________________________________ Completed:________________________