PAID OUT-OF-POCKET
RESTRICTION REQUEST FORM
FOR DISCLOSURE OF PROTECTED
HEALTH INFORMATION TO A HEALTH PLAN

In completing this form, you are requesting the following restrictions to the UT Health Science Center at San Antonio (UT Health Science Center) on disclosures of your protected health information to a health plan when you have paid out-of-pocket in full for this health care item or service. We are bound by the terms of the agreement.

Date of service: ____________ Name of health plan to restrict: __________________________

Requested Restrictions and Reason for Request:

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Print Patient Name: ________________________________

Record/Account #: ___________________

_________________________________________________________ Date

Patient’s Signature

_________________________________________________________ Relationship to Patient

Patient’s Legal Representative

For UT Health Science Center use only:

In regards to the request stated above, the UT Health Science Center: ___Accepts ___Denies

Reason (in-network service or bundled services): ____________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

_________________________________________________________ Date

UT Health Science Center Representative Signature