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 UT Health San Antonio 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 #: __________

Patient’s Signature ___________________________ Date ___________________________

Patient’s Legal Representative ___________________________ Relationship to Patient

For UT Health San Antonio use only:

In regards to the request stated above, UT Health San Antonio: _____Accepts _____Denies

Reason (in-network service or bundled services): ______________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

_____________________________ ___________________________
UT Health San Antonio Representative Signature Date