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