



**RESTRICTION REQUEST FORM  
FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

In completing this form, you are requesting the following restrictions be considered as limitations to UT Health San Antonio use and disclosure of your protected health information. If we agree to your request, we are bound by the terms of the agreement. You will be notified in writing of UT Health San Antonio's decision to accept or deny your restriction request. Until a decision is reached, your request for restriction will not be honored.

Requested Restrictions and Reason for Request:

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Print Patient Name: \_\_\_\_\_

Medical 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, the UT Health San Antonio: \_\_\_\_ Accepts \_\_\_\_ Denies

Reason: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
UT Health San Antonio Representative Signature

\_\_\_\_\_  
Date