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:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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 __________________________