



**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 #: _____

Patient's Signature

Date

Patient's Legal Representative

Relationship to Patient

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): _____

UT Health Science Center Representative Signature

Date