WESTMED
MEDICAL GROUP

Request to Restrict Uses and Disclosures of Protected Health Information

This form can be used to request that WESTMED Medical Group agrees to additional restrictions on the uses and disclosures of protected health information (PHI) about you. We call this a "Further Restriction Request." You may make such a request regarding uses and disclosures for treatment, payment, or health care operations, and uses and disclosures to family and friends involved in your care or payment for your care. The HIPAA Privacy Rule permits you to make a request, but it does not require us to agree to your request. This is described in our Practice's Notice of Privacy Practices.

To assist WESTMED Medical Group in responding promptly and accurately to your request, please complete this form in its entirety.

Patient Name: _____ **Patient Date of Birth**: _____
Print Name *Month/Day/Year*

Requested Restriction
Please describe in detail how you would like for our Practice to further restrict the use and disclosure of protected health information about you

_____

_____

_____

Reason for Further Restriction Request
Please specify the reason(s) for your Further Restriction Request

_____

_____

_____

I understand that it is my responsibility to notify other providers including hospitals, laboratories, doctors, etc. of my request for restriction on the care they provide related to this service. I understand that I can reverse this decision at any time by submitting a request in writing. I understand that I am responsible for costs incurred due to me changing my mind later on. I understand that I may be required to have testing repeated and that I may be responsible for co-payments and /or deductibles due because of the required testing.

I understand that it is also my responsibility to notify other providers including hospitals, laboratories, doctors, etc. of my decision to lift this restriction. Any request to release PHI that was denied based on the restriction must be resubmitted once the restriction is lifted.

Name of Patient or Personal Representative: _____
Print Name

Signature of Patient or Personal Representative: _____

Description of Personal Representative's Authority: _____

Date: _____

Please return form by using one of the methods listed:

- Mail to: Compliance Officer, Westmed Medical Group, 800 Westchester Avenue, Suite N-715, Rye Brook, NY 10573
- Fax: 914-719-4707
- *Email: Compliance@westmedgroup.com

**Disclaimer: Patients should carefully consider the use of email for the communication of protected health information (PHI) and should understand that there are known and unknown risks that PHI may be disclosed to, or intercepted by, unauthorized third parties. These risks include but are not limited to (i) the email being sent to the wrong person due to the sender's use of the wrong email address, (ii) e-mail service provider's ability to archive and inspect communications, and (iii) computer hacking and viruses.*