LEGACY HEALTH

RIGHT TO RESTRICT REQUEST FORM

Patient Name: Med Rec # Date of Birth: Today's Date Or attach patient Label

☐ Legacy Emanuel Medical Center
☐ Legacy Good Samaritan Medical Center
☐ Legacy Meridian Park Medical Center
☐ Legacy Mount Hood Medical Center
☐ Legacy Salmon Creek Medical Center
☐ Randall Children's Hospital at LegacyEmanuel
☐ Legacy Hospice
☐ Legacy Medical Group
☐ Laboratory Services, LLC:

PATIENT LAST NAME	PATIENT FIRST NAME	DATE OF BIRTH	
STREET ADDRESS	CITY	STATE	ZIP
CONTACT PHONE	CONTACT NAME (if not patient)	MEDICAL RECORD #	

Legacy Health will consider the right of a patient to request that Legacy restrict uses or disclosures of Protected Health Information (PHI) about the patient to carry out treatment, payment, or health care operations and disclosures to a relative, a personal friend or any other person identified by the patient of PHI about the patient that is directly relevant to such person's involvement with the patient's care or payment related to the patient's health care.

☐ GENERAL RESTRICTION

Legacy is under no obligation to agree to the request, and there will be no agreement unless Legacy informs the patient in writing that it agrees to the request. Even if Legacy agrees to the request, Legacy may continue to use or disclose the restricted information in the following situations:

- In a medical emergency when the information is needed for treatment
- When authorized in writing to use or disclose restricted information
- When the law requires the use or disclosure of restricted information

I request Legacy restrict the use or disclosure of my protected health information as specified below:

The health information I would like to have restricted includes:

I request that the above health information not be disclosed to:

301520

☐ **HEALTH PLAN RESTRICTION**

Patients have a right to restrict the disclosure of their PHI to a health plan if they pay for the service out-of-pocket in full at the time of service. The request must be made at the time services are rendered. The PHI pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full. Some of the physicians providing care to you, including but not limited to any radiologists, anesthesiologists, pathologists and emergency room physicians involved in your care are independent contractors and not agents or employees of Legacy. You should contact them to assure that they are aware and honor your Request for Restriction.

The health information I would like to have restricted includes:

I request that the above health information not be disclosed to:

Date of Service	Amount Paid	Acct #	Item of Service
Comments:			

Signature of Patient/Personal Representative _____ Date _____

Legacy Use Only - see LHS.700.16 & department specific procedure			
Date Received:	By:	Dept	Dept Phone#
Date Faxed to Privacy Office:	☐ Fax to Privacy Office 503.413.3407		
General Restriction: ☐ Accepted ☐ Denied Initials:		Date decision communicated to patient:	
DISTRIBUTION: Original – Patient Medical Record. Copy - Patient.			
Original 4/2003, Revised: 9/2013			