

FAX

512 Main Street, Suite 200
P.O. Box 8150
Rapid City, S.D. 57709
Ph: 605-399-7300
Fax: 605-399-7950

To:	Fax:
Attn:	Date:
From:	Pages:
Re:	Case/Cert:
<input type="checkbox"/> Urgent <input type="checkbox"/> For Review <input type="checkbox"/> Please Comment <input type="checkbox"/> Please Reply <input type="checkbox"/> Please Recycle	

Hello,
Following is a Restriction Request form, which when completed will restrict our use or disclosure of your Protected Health Information (PHI). Please complete the form and fax back to my attention at 605-399-7950. Below are instructions for completing the form.

Sincerely,

Section A – Individual requesting restriction. Print your name, address, and personal information.

Section B – First lines complete by stating what PHI you want to restrict. Example – Information regarding car accident
Second set of lines describe restriction you want to apply. Example – only give out to first wife.

Bottom of Page one – Individual's Signature - Sign and Date the form.

CONFIDENTIAL

CONFIDENTIALITY NOTICE: THIS FACSIMILE (INCLUDING ATTACHMENTS) IS COVERED BY THE ELECTRONIC COMMUNICATIONS PRIVACY ACT, 18 U.S.C. SECTION 2510-2521, IS CONFIDENTIAL AND MAY BE LEGALLY PRIVILEGED. IF YOU ARE NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY RETENTION, DISSEMINATION, DISTRIBUTION, OR COPYING OF THIS COMMUNICATION IS STRICTLY PROHIBITED. PLEASE REPLY TO THE SENDER THAT YOU HAVE RECEIVED THE MESSAGE IN ERROR, THEN DELETE IT. THANK YOU

RESTRICTION REQUEST

Purpose: This form is used for an individual's request to restrict our use or disclosure of protected health information.

SECTION A: Individual requesting restriction.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Identification Number: _____ Social Security Number: _____

SECTION B: To the individual—please read the following and complete the information requested.

You have the right to request that we restrict our use or disclosure of your protected health information for treatment, payment, or health care operations or to persons involved in your care or payment for that care. We are under no obligation to agree to your request. If we do, our agreement must be in writing and we will then restrict our use or disclosure of your protected health information as you request. We may, notwithstanding our agreement, use or disclose the restricted information needed for your treatment in an appropriate medical emergency, or when the use or disclosure without your written permission is authorized or required by law.

You may end the restriction at any time by notifying us in writing. We may end our agreement to restrict use or disclosure of your protected health information at any time by notifying you in writing. If you agree with our decision to end the restriction, your protected health information will no longer be subject to the restriction. If you disagree, our termination of the restriction will apply only to your protected health information that we create or receive after we gave you our notice terminating the restriction. To exercise your right to request restriction on our use or disclosure of your protected health information, please complete this Section B.

Please specify the protected health information, the use or disclosure of which you want to restrict:

Please state the restriction you want to apply to that protected health information:

INDIVIDUAL'S SIGNATURE.

I request that you restrict the use or disclosure of my protected health information as specified in Section B above. I understand that you are under no obligation to agree to my request, and that there will be no agreement unless you inform me in writing that you agree to my request.

Signature: _____ Date: _____

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Send completed and signed form to:

First Administrators, Inc.
Director of Compliance
512 Main ST, Suite 200
PO Box 8150
Rapid City, SD 57709