Drs. Bartlett & Esnard, PC at

Cardiovascular Disease and Invasive Cardiology

HEART OF GEORGIA CARDIOLOGY

POLICY 8.1

FORM REQUEST FOR LIMITATIONS AND RESTRICTIONS OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

You have the right under the Health Insurance Portability and Accountability Act of 1996 to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. We will comply with your request unless the information is needed to provide you emergency treatment. To request limitations and restrictions, you must complete this form and return it to us.

Patient Name: _____ Patient DOB: _____

Please list below the names and phone numbers of the individuals that we may release your information to, also indicate their relationship.

Name: _____ Relationship: _____ Phone #:_____

Name: _____ Relationship: _____ Phone #:_____

Name: _____ Relationship: _____ Phone #:_____

Name: _____ Relationship: _____ Phone #:_____

Please describe as specifically as possible ***how*** you would like this information to be restricted or limited.

_____

_____

_____ _____

Signature of Patient or Legal Guardian Date

Date received: ____/____/____ Employee: _____

HIPPA Officer: _____ Date signed: ____/____/____

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