Beth Israel Deaconess Hospital
Plymouth

PATIENT REQUEST TO RESTRICT USES AND DISCLOSURES OF PHI

1. I, _____, hereby request that the following restriction(s) be placed on the uses and disclosures of my personal health information by the Beth Israel Deaconess Hospital-Plymouth ("BID-Plymouth"):

   Note: Please give a full, specific description of the type of restrictions you are requesting regarding how and to whom your personal health information is used and disclosed. Restrictions may only be requested for those uses and disclosures that relate to your treatment, your payment or insurance, or the business operations of BID-Plymouth.

   Restriction(s):

   _____

   _____

   _____

   _____

2. I understand that BID-Plymouth is not required to agree to my restriction requests, but that BID-Plymouth is only required to attempt to accommodate reasonable requests when appropriate. I further understand that BID-Plymouth reserves the right to terminate an agreed-to restriction if it feels that termination is appropriate. I also have the right to terminate, in writing, any restriction by sending a termination notice to:

   BID-Plymouth
   Director of Health Information Services
   275 Sandwich Street
   Plymouth, Massachusetts 02360

Patient Name: _____

Patient Legal Representative Name: _____

Relationship to Patient: _____

Signature of Patient Name: _____ Date: _____

For Organizational Use Only:
Name/title of staff member who received this form: _____
Date form received: _____ Restriction Approved? Y/N _____
Name of Authorize Representative: _____

Form #1999