Request for Restrictions on Use and Disclosure of Health Information

Your Rights

You have the right to request a restriction on how we use, and with whom we share, your health information for treatment, payment, and administrative activities.

- **Carolinas HealthCare System is not required to agree to a restriction.** (With certain exceptions exceptions)
- **No restriction is effective until you receive written confirmation from Carolinas HealthCare System.**
- If we agree to a restriction, the restriction will be effective for the current specific patient visit or encounter specified and for future treatment, payment, or administrative activities.
- **In the event of an emergency situation, restriction agreements will not apply.**
- You may ask us at any time to end this restriction by telling us verbally or putting it in writing.
- We may end our agreement to the restriction by informing you in writing. This will only affect health information created or received after we have so informed you.

To request a restriction, complete this form in its entirety and submit it to the medical record custodian or designee of the CHS Facility or Practice where you were treated. To get the address of the appropriate Facility or Practice, please go to www.carolinashealthcare.org and select "Location".

Restriction on Use and Disclosure of Health Information

Name: _____ Date of Birth: _____

Street Address:

_____

City, State, Zip Code:

_____

Please specify the facility or practice from which you are requesting a restriction:

_____

Please describe the information to which this request applies (e.g., pregnancy test results):

_____

_____

Do not release my health information to the following person(s):

_____

Signature of Patient or Representative:

_____**Date:**_____

If signing as authorized representative, describe your authority to act for the patient, and submit documentation showing such authority, as appropriate:

_____

For Carolinas HealthCare System Use Only

_____ Request for restriction has been **denied.** (Note: The Facility may not deny a request for restriction from the Facility Directory.)

Please note reason for denial:

_____

_____

_____ Request for restriction has been **accepted**. In the case of an emergency or if necessary to comply with the law, the restriction agreement will not apply.

Signature(s): _____ Date: _____

Print Name & Title:

_____

Comments: _____

Original: File or Scan in medical record.