THE UNIVERSITY OF TOLEDO
MEDICAL CENTER

Request for Restrictions of Protected Health Information (PHI)

Release of Information Unit – Health Information Management
University of Toledo Medical Center
1015 Research Drive, Toledo, OH 43614
Phone: 419-383-4892 Fax: 419-383-3001

Patient Information	Restriction Response (UTMC to fill out)
Patient Name:_____ Birth Date:_____ SS#_____ Med Record # (optional): _____ Address:_____ _____ _____ Phone:_____	Date of receipt of request:_____ Your request for restriction has been: ☐ Approved ☐ Denied Reason:_____ Signature of UMC Privacy Officer: _____

I request that my protected health information **not** be disclosed to: (identify individual)

_____

For the following purposes: (treatment, payment or health care operations)

I understand that UTMC is not required to grant my request.
Please communicate the decision regarding this request to me at:

☐ Above stated address
☐ Other: _____
_____
_____

_____ _____
Signature of Patient or Legal Representative Date

_____
(Relationship to patient and authority to act in the patient's behalf

Termination of Previously Granted Restriction

The restriction set forth above is hereby terminated for the following reasons:

☐ Written request of the individual
☐ Oral request of the individual
☐ Written agreement of the individual
☐ Decision of UTMC

_____ _____
Signature of Patient or Legal Representative Date

_____
Signature of UTMC Privacy Officer

Submit