BELL CENTER FOR ANXIETY AND DEPRESSION

Request to Restrict Use or Disclosure of Protected Health Information

You have the right to request restrictions on how the Bell Center for Anxiety and Depression uses and discloses your health information for treatment, payment, and health care operations or to family and friends involved in your care. The Bell Center for Anxiety and Depression is not required to agree to your restriction, except when your request is that the Bell Center for Anxiety and Depression not disclose your health information to a health plan if you have paid for the health care item or service out of pocket, in full. If we agree to your restriction, we will not use or disclose your health information in violation of the restriction, unless such use or disclosure is necessary for emergency treatment, is required or permitted by law, or the restriction has been properly terminated.

If your request is to not disclose your health information to your health plan, you will be required to pay, in full for services rendered, or this request will be null and void and your health plan may be billed without your notice and you may be billed for any additional charges. During future visits to the Bell Center for Anxiety and Depression, providers may reference this restricted visit in their notes and those documents may be sent to your health plan to justify payment for future visits. This restriction request covers this, and only this particular visit, and if follow-up care is needed and you want that information restricted, you will need to fill out another form to cover each one of those visits.

Patient Name (print): _____

Patient Address: _____

_____

Phone Number: _____

E-mail: _____

Describe the restriction that you are requesting, including what information you would like to restrict and to whom the restriction will apply:

_____

_____

_____

_____

I am requesting that the Bell Center for Anxiety and Depression provide the above-described restriction of my health information. I understand the limits described above for this request regarding whether the Bell Center for Anxiety and Depression will grant this request and that payment in full will be required for restricting information provided to health plans.

Signature: _____ Date: _____

Patient or Person Authorized to Sign

If the consenting party is other than the patient, print name and relation to patient:

_____