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Vital Health
ENDOMETRIOSIS CENTER

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Request for Special Privacy Protections

Michelle Waterstreet, Privacy and Security Officer

As required by the Health Information Portability and Accountability Act of 1996, you have a right to request that we restrict our uses and disclosures of your protected health information with respect to treatment, payment and health care operations. You also have a right to request that we restrict our uses and disclosures of your health information with respect to disclosures to members of your family and other relatives or close personal friends or other person you identity who are involved in your care or payment for your care, or to notify or assist in notifying those individuals of your location, general condition or death. This medical practice does not have to agree to your request, but if we do, we will abide by our agreement until either of us terminates the agreement.

I hereby request special privacy protection for

____
(*print patient's name*)

☐ I **DO WANT** my health information/finances/appointments be disclosed to any of the following people:

Name	Relationship	Tel:	What CAN we share:

☐ I **DO NOT** want my health information/finances/appointments be disclosed to any of the following people:

Name	Relationship	Tel:	What CAN'T we share:

This request replaces and terminates any prior request for special privacy protection I may have made.

Signed: ______________________________ Date/Time: ______________________

NOTE: *By law, this restriction will not apply with respect to information necessary to provide emergency treatment, for uses or disclosures required by law, or for certain public health activities, judicial and administrative proceedings, law enforcement purposes, coroner investigations, organ or tissue donations, research activities, specialized government functions or workers' compensation activities.*

***For office use only*:**

Date Granted: ________________________ **Date Terminated:** ____________________

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