TELEMYND

Request to Restrict Use of PHI

Purpose: This form is intended for use by an individual to exercise his/her/their right to request to restrict use or disclosure of protected health information (PHI).

Individual requesting restriction.
Name:
Address:
Client I.D. Number:
Telephone: Email:

Please read the following and complete the information requested.

You have the right to request that we restrict our use or disclosure of your protected health information, including for treatment, payment, or our health care operations. We are under no obligation to agree to your request. If we do agree, our agreement must be in writing, and we will then restrict our use or disclosure of your protected health information as you request. We may, notwithstanding our agreement, use or disclose the restricted information in an appropriate medical emergency when the information is needed for your treatment, or when you authorize us in writing to use or disclose the information, or when the use or disclosure is required by law.

You may end the restriction at any time by notifying us in writing. We may end our agreement to restrict use or disclosure of your protected health information at any time by notifying you in writing. If you agree with our decision to end the restriction, your protected health information will no longer be subject to the restriction. If you disagree, our termination of the restriction will apply only to your protected health information that we receive after we gave you our notice terminating the restriction.

Please specify the protected health information, to be covered by the proposed restriction:

Please state the restriction you want to apply to that protected health information:

SIGNATURE.

I request Telemynd, Inc. to restrict the use or disclosure of my protected health information. I understand that Telemynd, Inc. is under no obligation to agree to my request, and that there will be no agreement unless Telemynd, Inc. informs me in writing that it agrees to my request.

Print Name: _____

Signature: _____ Date: _____

Personal Representative

If this request is being made by a personal representative on behalf of the individual, please provide a description and any available documentation of authority to act as the individual's personal representative and sign below.

Print name: _____

Signature: _____ Date: _____

Please send completed form to: HIPAA/Privacy Officer
141 Parker Street, Suite 306, Maynard, MA 01754

PLEASE KEEP A COPY OF THIS REQUEST FOR YOUR RECORDS.