Northwestern Medicine®

PATIENT REQUEST FOR RESTRICTION OF PROTECTED HEALTH INFORMATION

Patient Name ____

Patient Address ______________________________ City/State/ZIP ______________________________

Date of Birth ____________________ Phone ____________________

I request the following restriction in the way Northwestern Memorial HealthCare, through its clinical affiliates, uses (within NMHC), or discloses (outside of NMHC) my health information to carry out treatment, payment or healthcare operations:

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Type of service ____

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WHERE WERE YOU TREATED?

Hospital:

☐ Central DuPage Hospital
☐ Delnor Hospital
☐ Huntley Hospital
☐ Kishwaukee Hospital
☐ Lake Forest Hospital
☐ Marianjoy Rehabilitation Hospital
☐ McHenry Hospital
☐ Northwestern Memorial Hospital
☐ Palos Hospital
☐ Valley West Hospital
☐ Woodstock Hospital

Physician Group:

☐ Northwestern Medical Group (NMG) ☐ Regional Medical Group (RMG)

Other:

☐ Behavioral Health: Location(s) ______________________________

☐ Other ____

Please note that NMHC's clinical affiliates are not required under law to agree to your requested restriction, as it relates to use or disclosure of health information for treatment, payment or healthcare operations. NMHC's clinical affiliates may need to disclose your protected health information in order to fulfill our mission to provide quality health care to you. NMHC is required to comply with restriction requests related to disclosures of your health information to a health plan for purposes of payment or healthcare operations if the information relates to a healthcare item or service for which you have paid NMHC out-of-pocket in full. The restriction will apply only to those health records created on the date that you receive the item or service and made full payment out-of-pocket. If you do not want NMHC to bill your insurance for a particular service or item, you must tell the registration area and/or clinical practice where you receive the item or service at the time of treatment. NMHC will respond in writing whether or not its clinical affiliates can abide by your request.

NMHC is not responsible for disclosures made prior to approving your request.

Time ____________ Date ______________

Signature: Patient or Legally Authorized Patient Representative ______________________________

Relationship to Patient ______________________________

Send completed request forms to: Email: NMHPrivacy@nm.org. Fax: 312.926.7686.