Northwestern Medicine®

Patients' Privacy Rights Coordinator
Health Information Management
Email to nmhprivacy@nm.org
or Fax to 312.926.7686

PATIENT REQUEST FOR RESTRICTION OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Patient Address: _____ City/State/Zip: _____

Date of Birth: _____ SS# (last 4 digits) _____ 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 health care operations: _____

_____

_____

_____

_____

WHERE WERE YOU TREATED? Type of service: _____

_____

- ☐ Northwestern Memorial Hospital
- ☐ NM Marianjoy Rehabilitation Hospital
- ☐ NM Lake Forest Hospital
- ☐ NM Lake Forest Hospital – Grayslake
- ☐ NM Central DuPage Hospital
- ☐ NM Delnor Hospital
- ☐ NM Valley West Hospital
- ☐ NM Proton Center
- ☐ Northwestern Medical Group
- ☐ KishHealth System Physician Group
- ☐ Marianjoy Medical Group
- ☐ NM Kishwaukee Hospital
- ☐ NM KishHealth Ben Gordon Center
- ☐ NM KishHealth Cancer Center
- ☐ NM Cancer Center - Warrenville
- ☐ NM Cancer Center - Geneva
- ☐ Regional Medical Group
- ☐ Other _____

Please specify specialty/department:_____

_____

_____

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 health care 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 health care operations *if* the information relates to a health care 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.

_____ _____

Signature: Patient or Legally Authorized Patient Representative Date

Relationship to Patient _____

FOR INTERNAL USE ONLY
REQUEST APPROVED: _____Yes _____No Date of Restriction: _____
Restriction agreed to: _____
REQUEST DENIED: _____Yes _____No Date of Denial: _____
Reason for denial: _____
Patient or legal representative notified in writing on this date: _____