Request for Restriction of Use and Disclosure

Use this form to request or terminate a restriction of our use and disclosure of your protected health information (PHI).

If you need assistance in completing this form, please call the Trios Privacy Officer at 509-586-5883.

PLACE PATIENT LABEL HERE OR HANDWRITE	
Name:	**Date of Birth:**
Address:	
	Area Code & Telephone #:
E-mail Address:	

Restriction

☐ I would like Trios to bill me personally for today's service. I understand I have health plan coverage but wish not to bill them. I accept responsibility to pay this bill. My signature below overrides the consent to bill. I understand that this request applies only to today's visit and I will need to make a separate request for each visit that I wish to restrict.

☐ I wish to request the following restriction to the use and disclosure of my protected health information:

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☐ I wish to terminate a previous restriction to the use or disclosure of my PHI: □ Yes □No

Signature:

Date:

The form must be completed entirely. When complete send to:

Trios Health
Privacy Officer
900 S. Auburn St.
Kennewick, WA 99336

For Trios Privacy Officer Use Only:
Was the request granted? □Yes □No
If the request could not be granted, please explain:
If the request was granted, how was it communicated to all at Trios who will need to know?
Was the request logged in the Privacy Officer log? □Yes
When and how was the requestor notified of the decision?
[ ] Copy scanned into medical record [ ] Notes added to Patient Account/Practice Partner Plus [ ] Changed to Private Pay
Privacy Officer Signature:
Date: