UNIVERSITY HEALTH SERVICES
Tang Center

REQUEST FOR SPECIAL RESTRICTION ON USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Date: _____ Name: _____

SID: _____ DOB:_____

I understand that UHS may use or disclose my protected health information (PHI) for the purposes of treatment, payment and health care operations. I am requesting a special restriction on the use or disclosure of my PHI for these purposes. I understand that UHS does not have to agree to my request.

The information I want limited is: _____

_____

I want to limit: ☐ **UHS use of this information** ☐ **UHS disclosure of this information**
☐ **Both the use and disclosure of this information**
I want the restriction to apply to the following person/entity (if needed use extra sheet of paper):

_____

Even if UHS agrees to the restriction, it may share the information in the following circumstances as allowed by law:

- During the medical emergency if the restricted information is needed to provide emergency treatment. However, if the information is disclosed during an emergency, UHS will tell the recipient not to use or disclose it for any other purposes.
- For certain public health activities.
- For reporting abuse, neglect, domestic violence or other crimes.
- For health agency oversight activities or law enforcement investigations.
- For judicial or administrative proceedings.
- For identifying decedents to coroner and medical examiners or determining a cause of death.
- For organ procurement.
- For certain research activities.
- For workers' compensation programs.
- For uses or disclosures otherwise required by law.

If a special restriction is agreed to, it may be terminated if:

1. I request, or agree to, the termination in writing.
2. I orally agree to the termination and the oral agreement is documented.
3. UHS informs me that it is terminating the agreement. In this case, the termination is only effective for PHI created or received by UHS after I am notified of the termination.

Signature of patient or representative: _____

If representative, give relationship: _____

Date: _____

When you have finished filling out this form, please send it to: Health Records, University Health Services, The Tang Center, 2222 Bancroft Way, Berkeley, CA 945720-4300.

If you believe your privacy rights may have been violated, you may file a complaint with the University Health Services. To file a complaint with UHS, please write the Privacy Officer, UHS, 2222 Bancroft Way, Berkeley, CA 94720-4300. **You will not be penalized for filing a complaint**.

☐ UHS agrees to the restriction you requested. ☐ UHS does not agree to the restriction you requested.

Other _____

Signature of UHS Representative: _____ Date: _____

Name and Title of UHS Representative: _____