REQUEST FOR RESTRICTION OF PROTECTED HEALTH INFORMATION

Name_____ DOB_____ Acct #_____

I am requesting that Women's Health Texas (WHTX) restrict my protected health information from my insurance provider for my visit scheduled for: _____.

By completing this form, I understand that:

- **I am required to pay, in-full**, the projected amount for my services before they occur or this request will be null and void and my insurance may be billed without notice and I may be billed for any additional charges that must be paid within thirty (30) days of my service
- This form only covers the **professional portion of the bill** and that I may need to contact the following areas to ensure they do not send my PHI to my insurance company:
    - My provider – Physicians and facilities may bill separate and I may need to contact the facility to request they do not send PHI to my insurance company and obtain a restriction on their billings.
    - Pharmacy – I will need to ask my prescribing provider to provide me with a paper prescription to ensure that my medication is not billed or disclosed to my health plan
    - Lab – I understand that some lab tests are done by an external vendor and I may have to contact one of them to obtain a restriction from their billing:
- During future visits to WHTX, providers may reference this restricted visit in their notes and that those documents may be sent to my insurance provider to justify payment for those future visits.
- WHTX will not redact or alter those notes to reflect this restriction request.
- **This restriction request covers this, and only this particular visit, and if follow-up care is needed that I want this information restricted, I will need to fill out another form to cover each one of those visits**
- As federal law changes, the rules around this restriction may change as well.

You may request to revoke this restriction only in writing.

Signature

I request WHTX to restrict the use or disclosure of my protected health information as specified above.

Patient/Representative Signature:_____Date: _____

REVOCATION OF DO NOT FILE RESTRICTION:

I request that WHTX **REVOKE my previous restriction described above.**

Patient/Representative Signature:_____ Date: _____