TRYON MEDICAL
PARTNERS

REQUEST FOR RESTRICTION OF USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I understand that I have the right to request restriction(s) as to how my PHI may be used and/or disclosed to carry out treatment, payment, or health care operations, or disclosed to family members and others involved in my care. I understand:

- Tryon Medical Partners may **not** be required to agree to the restriction(s) requested.
- Even if my request for restriction is denied, I will generally have an opportunity to agree or object prior to disclosures to persons involved in my care.
- If Tryon Medical Partners agrees to a requested restriction, it will be binding for current specific encounter(s) and for future treatment, payment, or business operations.
- **In the event of emergency situations, restriction agreements will not apply**.

To submit: (1) Return form to your Tryon doctor's office, (2) submit via the patient portal, (3) fax to 980-237-4974, **or** (4) mail to: Privacy Officer, Tryon Management Group, 5960 Fairview Road, Suite 500, Charlotte, NC 28210.

You may expect to receive a response to your request within 60 days of our receipt of this form.

Patient Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Email:** _____

PLEASE SPECIFY REQUEST:

☐ **I request to restrict use and disclosure of my information for the treatment, payment, or operations related purpose described here:** _____

_____

☐ **I request to restrict use and disclosure of my information to the following person or entity (provide name of person & relationship, or entity name):** _____

_____

☐ **I am requesting that a prior, agreed upon restriction, be discontinued** *(describe prior restriction request and approximate timeframe it was submitted)*: _____

_____

I understand that completion of this form does not mean this request has been accepted. This request will be reviewed by Tryon's Privacy Compliance Office, and I will be informed if this request is accepted.

SIGNATURE

_____ _____

Signature of Patient or Authorized Representative** **Date**

If not patient, please indicate relationship: _____

*** Must provide proof of legal authority (except parent of minor)*

For Privacy Compliance Office Use Only:

☐ ACCEPTED ☐ DENIED Comment: _____

_____ _____

Signature of Patient or Authorized Representative** **Date**