MEDICAL ASSOCIATES OF NWA, P.A.
FORM FOR REQUESTING RESTRICTIONS ON USES AND DISCLOSURES

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

As a patient of Medical Associates of NWA, P.A. ("MANA"), you have the right to request that we restrict: (1) certain uses and disclosures of your protected health information (PHI) that we make for purposes of treatment, payment, or health care operations; or (2) disclosures of your health information to family members, personal friends, or other people involved with your care or payment for care. Except as provided below, MANA is not required to agree to your requests, but any restrictions we agree upon are binding, and no employee of MANA may violate the restrictions agreed upon. However, in emergency situations, it may be necessary to use or disclose restricted information in order to provide you with care. If, in such a situation, another entity must be given access to restricted information, MANA must request that the receiving entity not further use or disclose that information. The provisions set forth above are subject to the following exceptions:

1. Our agreement to a restriction request is not valid to prevent:
    a. Disclosure of PHI when required by HHS to investigate or determine our compliance with HIPAA; or
    b. Uses or disclosure for which your Authorization is not required; and
2. MANA must agree to a request to restrict disclosure of your PHI to a health plan if:
    a. The disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and
    b. The PHI pertains solely to a health care item or service for which you or someone acting on your behalf has paid the covered entity in full.

I request that the following portion of my PHI be restricted when used or disclosed by MANA: (Describe medical information to be restricted below.)

_____

_____

_____

_____

I request that the following restrictions be applied by MANA to its own uses and disclosures of that information: (Describe nature of desired restriction (s) below.)

_____

_____

_____

_____

MANA must process your request and notify you of its decision within **30** days.

MANA's agreement to the above restrictions will not affect:

1. Your right to review and copy your PHI.
2. Your ability to receive an accounting of disclosures of your PHI.
3. Uses and disclosures that do not require your consent, Authorization, or an opportunity for you to agree or object, such as disclosures required by law.

MANA's agreement to a restriction may be terminated if one of the following criteria is met:

1. You agree to or request the termination in writing;
2. You orally agree to the termination and the oral agreement is documented; or
3. MANA informs you that it is terminating its agreement to a restriction. In this circumstance, only PHI created or received after the termination will not be restricted. **The restrictions will continue to apply to:**
   (a) any information created or received prior to the termination; and
   (b) any information for which you requested a restriction pertaining to a health care item or service for which you or someone acting on your behalf paid the covered entity in full.

By signing below, I affirm that the information above is correct and current.

_____ _____

Signature of Patient or Patient's Representative Date

(Client must be provided a copy of this form at the time the request is made.)

FOR ADMINISTRATIVE USE ONLY Name of Reviewer _____ Date _____	
Request to Restrict Uses and Disclosures Accepted: ☐ In whole ☐ In part, as follows Description:	Request to Restrict Uses and Disclosures Denied ☐ In whole ☐ In part, as follows Description: