CARRBORO FAMILY MEDICINE CENTER, P.A.

Patient Centered. Community Based.

Please Note:

REQUEST RESTRICTIONS ON PHI USE AND DISCLOSURE INFORMATION

As a patient of Carrboro Family Medicine you have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for care, such as a family member or friend. We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively affect the care we provide you.

lf we do agree, we will comply with your request, unless the information is needed to provide emergency treatment. To request a restriction, you must **make your request in writing** to this office's Medical Records Department on the **Request Restrictions on the Use and Disclosure of PHI form**. In your request, you must tell us what information you want to limit and to whom you want the limits to apply.

Carrboro Family Medicine Center, P.A.
610 Jones Ferry Road, Suite 102
Carrboro, North Carolina 27510
Telephone: 919-929-1747 • Fax 919-933-5168
www.carrborofamilymedicine.net

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REQUEST RESTRICTIONS ON PHI USE AND DISCLOSURE

REQUEST

I understand that Carrboro Family Medicine, PA may use and disclose ALL protected health information about me for purposes of treatment, payment and operations. I request that Carrboro Family Medicine, PA restrict the use and disclosure of protected health information about me as described below. I understand that Carrboro Family Medicine, PA is not required to agree to this restriction. I understand that if Carrboro Family Medicine, PA agrees to this restriction, either Carrboro Family Medicine, PA or I may terminate this restriction at any time. The termination of the restriction is only effective for future uses and disclosures.

I understand that if protected health information must be used or disclosed to provide emergency treatment for me, than this restriction is void.

INFORMATION:

Patient Name: _____

Date of Birth:_____

Street Address:_____

Telephone Number: _____ E-mail Address: _____

QUESTIONNAIRE

Please complete all of the following question. If the question is not applicable, mark N/ A on the answer line.

I request the following information be restricted (description of information):

_____

_____

_____

I request that use and disclosure of the above described information be restricted in the following manner (description of restriction):

_____

_____

_____

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I request that my protected health information not be disclosed to the following individuals or entities (list individuals or entities to which information should not be disclosed):

SIGNATURE

I understand that if a restriction is not specifically listed above and agreed to in writing by Carrboro Family Medicine, it will not be effective.

Print Name:_____

Signature:_____

Date: _____

If signed by the patient's personal representative, explain authority to act on behalf of the patient:

Note: If you are signing this form as the legal representative of the individual listed above, and are other than the parent of the minor child whose information is listed above, you must also submit documentation that establishes yourself as the legal representative. For example, a copy of a Power of Attorney that includes provisions to obtain medical information, etc.

_____

_____

_____

Mail this completed and signed form to
Carrboro Family Medicine, PA
Suite 102 Carrboro, NC 27510;
Phone: (919) 929-1747; Fax (919) 933-5168.

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