CEDARS-SINAI MEDICAL CENTER

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

Date: _____

Patient Name: _____

Social Security Number: _____

Date of birth: _____

I understand that **Cedars-Sinai Medical Center** may use or disclose my protected health information ("PHI") for the purposes of treatment, payment and health care operations. Cedars-Sinai Medical Center ("Medical Center") may also disclose information to someone involved in my care or the payment for my care, such as family member or friend. I understand that the Medical Center does not have to agree to my request except in the limited situation in which I request a restriction on the disclosure of information about a health care service or related item to a health plan for the purposes of payment or health care operations and I or someone else has paid in full for that service or item[1].

I hereby request a restriction on the Medical Center's use or disclosure of my protected health information.

The information I want limited is:

_____

_____

_____

I want to limit:

- ❑ The Medical Center's use of this information.
- ❑ The Medical Center's disclosure of this information.
- ❑ Both the use and the disclosure of this information.

I want the limits to apply to the following person / entity (for example, a spouse):

_____

If the Medical Center agrees to the restriction, it may share the information in the following circumstances:

- During a medical emergency if the restricted information is needed to provide emergency treatment. However, if the information is disclosed during an emergency, the Medical Center will tell the recipient not to use or disclose it for any other purposes.

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[1] Please contact the Patient Financial Advocate Unit at 310-423-4890 for assistance with restricting disclosures to a health plan when the item or service is paid in full out of pocket.

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

- Inclusion in the Medical Center's directory.
- 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 worker's 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 the termination in writing.
2. Orally agree to the termination and the oral agreement is documented.

For more information about this form and its contents, please contact the Health Information Manager at (310) 248-6674.

For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website at **www.csmc.edu** or contact the Cedars-Sinai Medical Center Privacy Manager at (323) 866-7877 or send a written request to Privacy Manager, Cedars-Sinai Medical Center, 8700 Beverly Boulevard, Los Angeles, California 90048.

If you believe your privacy rights have been violated, you may file a complaint with the Medical Center or with the Secretary of the Department of Health and Human Services. To file a complaint with the Medical Center, contact the Privacy Manager at (323) 866-7877. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

_____

Signature of patient or representative

_____

Telephone Number

_____

If representative, give relationship