Blanchard Valley
HEALTH SYSTEM

PATIENT REQUEST TO RESTRICT USES AND DISCLOSURES OF PERSONAL HEALTH INFORMATION

I, [**Insert patient's name**], hereby request that the following restriction(s) be placed on the uses and disclosures of my personal health information by BVHS:

Please give a full, specific description of the type of restrictions you are requesting regarding how and to whom your personal health information is used and disclosed. Restrictions may only be requested for those uses and disclosures that relate to your treatment, your payment or insurance, or the business operations of BVHS.

LIST OF RESTRICTIONS REQUESTED

I understand that BVHS is not required to agree to my restriction requests, but that BVHS is only required to attempt to accommodate reasonable requests when appropriate. I further understand that BVHS reserves the right to terminate an agreed-to restriction if it feels that termination is appropriate, and that I also have the right to terminate, in writing, any restriction by sending a termination notice to the BVHS Privacy Officer, 1900 South Main Street, Findlay, OH 45840.

_____

Patient Name

_____

Name of personal representative, if applicable

_____

Relationship of personal representative to patient

_____

Signature of patient (or patient's representative) and Date