Request to Exercise Privacy Rights – Restrict the Use or Disclosure of PHI

Date _____

Patient name _____

Date of birth _____ Phone number _____

Street address _____

City _____ State _____ Zip Code _____

This form lets you exercise the privacy rights that you have under federal law. **You have the right to ask Novant Health to restrict uses or disclosures of your protected health information (PHI) for:**

- Treatment, payment or healthcare operations;
- Disclosures to people involved in the patient's healthcare or payment for healthcare; and
- Disclosures to notify family members or others about the patient's general condition, location, or death

Instructions:

Please explain in detail to whom you do not want your information given and/or what information to restrict. Please describe the relationship to you of people listed. Please use dates of service or specific PHI you want restricted and why.

Contact Novant Health Privacy Office at 704-384-9829 if you have any questions.

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_____ _____ _____ _____

Patient signature | Date/time | Legal Representative/relationship | Date/time

For Office Use Only

☐ Request granted _____

☐ Request granted in part _____

☐ Request denied _____

_____

_____

Leadership signature-title _____ Date/time _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter accepted _____ ☐ Interpreter refused

(Name/number of person/services chosen/used)