



# DEPARTMENT OF MENTAL HEALTH

## CLIENT'S REQUEST FOR RESTRICTION ON USE AND DISCLOSURE OF HEALTH INFORMATION

Client Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

MIS #: \_\_\_\_\_

1. I understand that DMH may use or disclose my protected health information ("PHI") for the purposes and under the circumstances described in the DMH *Notice of Privacy Practices*, and that otherwise, DMH must not use or disclose my PHI.

2. I understand that I may request that DMH refrain from certain uses or disclosures of my PHI that the law would otherwise allow. Specifically, I understand that I may request that DMH refrain from using or disclosing my PHI for any of the following purposes:

- a. For my treatment;
- b. To obtain payment for services rendered to me;
- c. For its various "health care operations", as defined by federal law;
- d. If I do not object, to family members, individuals involved in my care or payment for my care; and
- e. If I do not object, to disaster relief agencies.

3. I also understand that even though I have the right to ask that DMH not make one or more of these disclosures, DMH does not have to agree to my request.

4. If you ask us to restrict our uses and disclosures of your PHI even more than the law requires, and if we agree to do so, we are required to honor that agreement. We will notify you in writing as to whether or not DMH will agree to or will deny your restriction request. Until a decision is made, we will continue to use and disclose your PHI as allowed or required by law.

5. I hereby request that DMH agree to limit its use or disclosure of my PHI as follows:

- a. The information I want to have specially protected is:

_____
_____
_____
_____



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- b. I want to limit:
- The inside use of this information by DMH (i.e., the communication of this PHI among DMH workforce personnel for otherwise lawful purposes).
  - The outside disclosure of this information by DMH (i.e., the communication of this PHI to persons or organizations outside of DMH, for otherwise lawful purposes).
  - Both the inside use and the outside disclosure of this information.
- c. Complete, only if applicable: I do not want the following person/entity to receive the information described in paragraph 5.a above: \_\_\_\_\_

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Signature of client or representative: \_\_\_\_\_

If representative, give relationship: \_\_\_\_\_

### DENIAL OF REQUEST

Until further notice, as permitted by the federal Privacy Regulations, DMH will not be able to agree to your request for restriction.

Signature of Treatment Provider: \_\_\_\_\_

Date: \_\_\_\_\_