

**HEALTH CARE SYSTEM  
REQUEST FOR RESTRICTIONS FOR USE AND DISCLOSURE OF PHI**

Patient Name \_\_\_\_\_ Medical Record Number \_\_\_\_\_

Date of Birth \_\_\_\_\_ Phone # \_\_\_\_\_

Patient Address \_\_\_\_\_  
\_\_\_\_\_

I request that the University of North Carolina Health Care System (UNC HCS) restrict the use or disclosure of protected health information about me in the manner described here (please be specific, i.e. the information to be restricted, dates of creation of the information, how you wish UNC HCS to restrict its use or disclosure of the information, the reason for request):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that UNC HCS is not required by law to accept my requested restrictions, but if accepted, UNC HCS agrees to abide by the restrictions, except in emergency situations. I also understand that any accepted restriction is not effective to prevent uses or disclosures which are: permitted or required by law without my authorization or the opportunity to object, requested by the Secretary of the Department of Health and Human Services, for directory purposes (unless I have objected to being included in the directory), or uses or disclosures made prior to acceptance date..

I understand that if this request is accepted and put into place, it may make the provision of care to me more difficult and/or less effective.

I understand that either UNC HCS or I may terminate this restriction in writing at any time in the future. If UNC HCS terminates its agreement to the restriction, I understand I must either agree in writing or orally to the termination, or UNC HCS may inform me of the termination and make it effective only for protected health information created or received after it has informed me of the termination.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

If signing as authorized representative, describe authority to act for patient and submit documentation showing such authority: \_\_\_\_\_

**UNC HCS USE ONLY**

Date request received: \_\_\_\_\_ Accepted or Denied (circle one)

If denied, state reason for denial \_\_\_\_\_

Signature of staff member: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_