REQUEST TO RESTRICT DISCLOSURE TO HEALTH PLAN
{Authorized by Section 13405(a) of the HITECH Act}

I request that ***{Name of Provider}*** (the "Practice") not disclose my protected health information (PHI) to my health plan or other third party insurance carrier. Pursuant to Section 13405(a) of the HITECH Act, I understand I have the right to request restrictions on whether the Practice discloses my protected health information (PHI) with my health plan and the Practice is required to agree to my request unless the information is required to be disclosed to my health plan to comply with the law.

The records of the restricted services/items listed below ("Restricted Services/Items") will not be released or billed to my health plan or other third party insurance carrier for the purposes of payment or health care operations. **I understand I am financially responsible for these Restricted Services/Items and will pay out-of-pocket, in full, at the time of service in order for the Practice to accept this restriction request.**

REQUESTED RESTRICTION:

Services/Items to be restricted: ____

____

Total Charge Amount (or estimated amount): $__________ per treatment/per month (circle one)
Other:
____

(I understand that I am responsible for full charges when finalized)

Signed by: ____ Date: ____________

PRACTICE USE ONLY:

Obtained by: ____ Date: ___________

Print Patient Name: ____

Print Patient Address: ____