Patient Name: _____

Date of Birth: _____

Medical Record Number: _____

(Please Print)

GUNDERSEN
HEALTH SYSTEM®

PATIENT RIGHT TO RESTRICT ACCESS TO HEALTH INFORMATION

I am requesting the following restriction to my health information:

_____

_____

_____

Purpose of Restriction Request: _____

_____

I understand that Gundersen Health System reserves the right to deny requests for restrictions for treatment, payment, healthcare operations or other requests.

I understand I have the right to terminate this request at any time by contacting Gundersen Health System's Privacy Office at (608) 775-7439.

Signature of Patient: _____ Date: _____

_____

(If signed by authorized person, state relationship and authority to do so.)

****

FACILITY USE ONLY:
Date Request Reviewed: _____ Name of Reviewer: _____
Request above is: Approved _____ Denied: _____
Reason for Denial: _____
Reviewer's Signature: _____ Date: _____
DATE COPY OF FORM MAILED TO PATIENT FOR APPROVAL/DENIAL: _____

****

FOR INTERNAL USE ONLY:
Send original to Privacy Office (Mailstop NCA2-08)
Privacy Office will scan into patient's medical records under doc type: Release of Information
Date Scanned: _____