



CORE DATA • REQUEST FOR RESTRICTIONS

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

You have the right to request restrictions on the ways in which Stanford Hospital and Clinics and Lucile Packard Children's Hospital (the Hospital) use and disclose your personal health information. **The Hospital is not required to agree to your request.** If the Hospital agrees to your request, then we will be bound by the restriction unless the information is needed to provide you with emergency treatment or to comply with the law.

I am requesting the following restriction(s):

- For this admission, I do not want my name to appear in the Hospital's patient directory
- For this admission, I do not want my name to appear on lists provided to the Hospital's Spiritual Care Services / Chaplaincy Office
- Other: The information I wish to restrict is: _____

I want to restrict:

- The Hospital's disclosure of this information

I want the restriction to apply to the following person / entity (e.g. a spouse): _____

If you checked the box labeled "Other", the Hospital will review your request and provide you with a written response. Depending upon the nature your request, it may take several days to respond. Until your request has been accepted, the Hospital will use and disclose your health information in a manner consistent with our Notice of Privacy Practices and applicable law.

Examples of restriction requests that the Hospital cannot honor:

- Requests to restrict medical students or residents from accessing your medical information.
- Requests restricting the Hospital from giving your name to an insurance company that will be asked to pay a portion of your bill.
- Requests restricting the Hospital from reporting your identity and condition to an agency or organization where the Hospital is required by law to do so.

Signature: _____ Date: _____

If other than the patient, specify relationship: _____

If interpreted: _____		
<i>Interpreter Signature</i>	<i>Print Name</i>	<i>Language</i>
<i>Date</i>	<i>Time</i>	<i>Position/Relationship to Patient</i>

After the Hospital has accepted a restriction, it may be terminated if:

1. You request in writing that the restriction be terminated. Address correspondence to SHC/LPCH Privacy Office, 300 Pasteur Drive, Stanford, CA 94305-5202. Please include a copy of the original request or the date, patient name and medical record number that appeared on the accepted restriction request, OR
2. The Hospital informs you in writing that it is terminating the restriction. In this case, the termination only applies to your personal health information created or received by the Hospital after you have been notified of the termination.

For Hospital Use Only: <input type="checkbox"/> Request Accepted <input type="checkbox"/> Denied		
Name: _____	Title: _____	Date: _____

Same As 1