

Dallas Arthritis Center, P.A.

REQUEST FOR RESTRICTION OF INFORMATION

Disclosure of Healthcare Information

Dallas Arthritis Center, P.A. (DAC) Notice of Privacy Practices provides information about how DAC may use and disclose protected health information about you. A copy of the current Notices will be distributed to you by a Registration Representative. The notices contain on the first page, in the top right hand corner, the effective date. As provided in the Notices, the terms of the Notices may change.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

My Presence and Condition

I **(do)** **(do not)** request to be classified as a “no information” patient. I understand that I will be responsible for informing those people of my presence in DAC, of my location, and telephone number in DAC. Further, I understand that DAC is not responsible for any disclosures regarding my presence in DAC that are made by people that I inform of my presence in DAC.

I understand that if DAC agrees to classify me as a “No Information Patient”, this restriction will have no impact on DAC’s right to disclose and use my protected health information for purposes of treatment, payment and health care operations.

Under some conditions DAC may find it necessary to impose the “No Information “ Status on patients because the law demands it or for patient safety and the safety of the staff. If this status is deemed necessary, this status places a special responsibility to maintain confidentiality on you, the patient, your family or others who may be aware of the treatment. Failure to cooperate may require DAC to revoke the status.

_____ A copy of DAC Privacy Notice has been provided.

By signing below you acknowledge this request and agree to help us maintain this status until further notice,

Signature (and relationship if not patient)

Witness

Date

Print Name _____

Implemented by: _____ Date: _____

Signature of Supervisor

Revoked by: _____ Date: _____

Signature of Supervisor