REQUEST FOR RESTRICTION OF PROTECTED HEALTH INFORMATION AND COMMUNICATIONS

Patient Name: _____ Date of Birth: _____

Medical Record # (if known): _____

Address: _____

Phone (optional): _____

I understand that Fox Valley Psychiatry (FVP) may use or disclose my protected health information (PHI) for the purposes of treatment, payment, or health care operations. Fox Valley Psychiatry may also disclose information to someone involved in my care or the payment for my care, such as a parent or legal guardian. I understand that Fox Valley Psychiatry does not have to agree to my request to restrict my PHI.

I hereby request a restriction on FVP's use or disclosure of my PHI to the following person/entity:

_____

I want to limit the following protected health information:

_____

_____

I want to limit Fox Valley Psychiatry's:

❒ Use of this information ❒ Disclosure of this information ❒ Both the use and the disclosure of this information

If a special restriction is agreed to, it may be terminated if:

- I request, or agree to, the termination in writing.
- I orally agree to the termination and the oral agreement is documented.
- Fox Valley Psychiatry informs me that it is terminating the agreement. In this case, the termination is only effective for PHI created by Fox Valley Psychiatry or received by FVP after I am notified of the termination.

I hereby request Fox Valley Psychiatry to communicate with me about my medical matters confidentially. I request Fox Valley Psychiatry to contact me in a certain way or at a certain location. My preferred communications is / are:

❒ Telephone (list phone number): _____

❒ Writing (provide mailing address): _____

Additional information (if it is applicable to your request):

_____

_____

If you believe your privacy rights have been violated, you may file a complaint with Fox Valley Psychiatry or with the Secretary of the Department of Health and Human Services, Office of Civil Rights. To file a complaint with Fox Valley Psychiatry, contact the Privacy Office: (920) 882-7780. You may also submit your complaint in writing and deliver to: Fox Valley Psychiatry Compliance Department, 4321 W College Ave, Ste 200, Appleton, WI 54914. **You will not be penalized for filing a complaint.**

| Signature (Patient Or Person Authorized To Give Consent) | Printed Name | Date |
|---|---|---|
| | | |
| If signed by person other than patient: print name, relationship to patient, reason for alternate signing | | |
| | | |

**This authorization form can be faxed to us (preferred) or sent by postal mail.**

Fax

920-214-1187

Mail

Attn: Medical Records Fox Valley Psychiatry Ltd.
4321 W College Ave, Ste 200, Appleton, WI 54914

Phone

(920) 882-7780 (call if you have questions about this form)

fox valley
PSYCHIATRY
2024