uchealth

Request for Restriction on Uses and Disclosures of Protected Health Information

Select the UCHealth facility/group from which you are requesting restriction:

- ☐ Broomfield Hospital
- ☐ Estes Valley Medical Center
- ☐ Grandview Hospital
- ☐ Greeley Hospital
- ☐ Highlands Ranch Hospital
- ☐ Longs Peak Hospital
- ☐ Medical Center of the Rockies
- ☐ Memorial Hospital
- ☐ Parkview Medical Center
- ☐ Parkview Pueblo West Hospital
- ☐ Pikes Peak Regional Hospital
- ☐ Poudre Valley Hospital
- ☐ University of Colorado Hospital
- ☐ Yampa Valley Medical Center
- ☐ UCHealth Medical Group

☐ Other Facility/Provider _____

Patient name _____ Date of birth _____

Name of requesting individual _____ Date/Time of request _____

Address _____

Describe the restriction on UCHealth's uses and disclosures of your health information that you are requesting:

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Information Regarding Your Rights to Request a Restriction

You have the right to asked us to restrict how UCHealth uses and discloses your health information for purposes of treatment, payment, or health care operations (See *Notice of Privacy Practices* for more information on these types of uses and disclosures.) You also have the right to ask us to restrict disclosures that we make for notification purposes or to those family members or others who are involved in your care or involved in payment for your care. We are not required to agree to your request. If we do agree, we will put it in writing and will abide by the agreement as permitted by law, except when you require emergency treatment. If we do not agree to your request, we will notify you of our decision in writing.

By submitting this form, I hereby request UCHealth to restrict uses and disclosures of my health information as described above and until we decide to terminate the agreement. I understand that UCHealth is not required to agree to my request.

Name of patient (printed)	Name of staff who received request (printed)
Signature of patient or legally authorized representative	Signature of staff who received request
Relationship to patient	Date Time
Date Time	

—FOR UCHEALTH INTERNAL USE ONLY—

Date/Time received _____ Accepted _____ Denied _____

If denied, list reason(s) for denial _____

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_____

Individual was informed of acceptance or denial in writing _____

Signature of UCHealth representative _____ Date/Time _____

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Solicitud de restricción del uso y de la divulgación de información de salud protegida

(Request for Restriction on Uses and Disclosures of Protected Health Information)

Seleccione el centro o grupo de UCHealth del cual está solicitando la restricción:

- ☐ Broomfield Hospital
- ☐ Estes Valley Medical Center
- ☐ Grandview Hospital
- ☐ Greeley Hospital
- ☐ Highlands Ranch Hospital
- ☐ Longs Peak Hospital
- ☐ Medical Center of the Rockies
- ☐ Memorial Hospital
- ☐ Parkview Medical Center
- ☐ Parkview Pueblo West Hospital
- ☐ Pikes Peak Regional Hospital
- ☐ Poudre Valley Hospital
- ☐ University of Colorado Hospital
- ☐ Yampa Valley Medical Center
- ☐ UCHealth Medical Group

☐ Other Facility/Provider _____

Nombre del paciente _____ Fecha de nacimiento _____

Nombre de la persona solicitante _____ Fecha/Hora de la solicitud _____

Dirección _____

Describa la restricción que usted desea y a la que usted solicita que UCHealth se adhiera, en el uso y la divulgación de su información de salud:

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Información sobre su derecho a solicitar una restricción

Tiene derecho a solicitar que restrinjamos de qué manera UCHealth usa y divulga su información de salud, con motivo de tratamiento, pago, o para la administración de atención de salud (Vea el documento *Aviso sobre prácticas de privacidad* para mayor información sobre dichos tipos de usos y divulgación de información.) Además, usted tiene derecho a solicitar que restrinjamos la divulgación de información que realizamos con fines de notificar o divulgar información a parientes u otras personas quienes estén involucrados en su atención de salud, o a quienes estén involucrados en el pago por su atención de salud. No estamos obligados a aceptar o a asentir a su solicitud. Si aceptáramos su solicitud, lo documentaremos por escrito y cumpliremos con lo acordado según lo permita la ley, excepto en caso en que usted requiera tratamiento de emergencia. En caso que no aceptáramos su solicitud, le notificaremos nuestra decisión por escrito.

Al presentar el presente formulario, solicito en virtud de este acto que UCHealth restrinja el uso y la divulgación de mi información de salud según se detalla anteriormente en el presente documento, y hasta que decidamos poner fin al presente acuerdo. Entiendo que UCHealth no tiene obligación de aceptar mi solicitud.

Nombre del paciente (en letra de molde)	Name of staff who received request (printed)
Firme del paciente o representante legal autorizado	Signature of staff who received request
Parentesco co el paciente	Date Time
Fecha Hora	

—FOR UCHEALTH INTERNAL USE ONLY—

Date/Time received _____ Accepted _____ Denied _____

If denied, list reason(s) for denial _____

_____

_____

_____

Individual was informed of acceptance or denial in writing _____

Signature of UCHealth representative _____ Date/Time _____