UNIVERSITY OF UTAH
HEALTH CARE

PATIENT REQUEST FOR SPECIAL PRIVACY RESTRICTION

Name of Patient ____ **Date of Birth** ________________________

Medical Record # ___________________________________ **Phone #** _______________________________

Patient Address ____

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Patient Email Address ____

I request that the University of Utah Health Sciences ("UUHS") restrict the use or disclosure of my protected health information for treatment, payment, or health care operations in the manner described here (please be specific):

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I understand that the UUHS is not required by law to accept my requested restrictions, but if accepted, the UUHS agrees to abide by the restrictions except in emergency situations. **I understand that if this request is accepted and put into place, it may impact my care and/or safety negatively.** I also understand that either I or the UUHS may terminate this restriction in writing at any time in the future.

____
Signature of Patient or Representative Date

____
If Applicable, Name of Personal Representative*

*Description of Personal Representative Authority

- ☐ Parent
- ☐ Foster Parent
- ☐ Guardian
- ☐ Power of Attorney
- ☐ Other, Explain, attach:

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Patients: Bring this form to Health Information, or mail to: Health Information, 50 N. Medical Dr., Salt Lake City, UT 84132

A notarized signature is required unless the patient or personal representative's ID is verified by UUHS staff.

SUBSCRIBED AND SWORN before me this ____ day of ________________, 20____.

____
NOTARY PUBLIC

Residing in _______________________________

My Commission expires: ____________________