REQUEST TO RESTRICT MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.

AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the patient with a means to request a restriction on the use and disclosure of his/her protected health information.
ROUTINE USE(S): To other entities or physicians for: judicial and administrative purposes; health oversight; research; law enforcement; public health; to avert a serious threat to health and safety; organ, eye, or tissue donation; decedents; Worker's Compensation; victims of abuse, neglect, or domestic violence; specialized government functions; and required by law.
DISCLOSURE: Voluntary. Failure to sign the authorization form may result in a release of the protected health information.

This form will not be used to request restrictions on the use or disclosure of any alcohol or drug abuse patient information from medical records of an alcohol or drug abuse treatment program.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY/IDENTIFICATION NUMBER

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)*
-	☐ OUTPATIENT ☐ INPATIENT ☐ BOTH

SECTION II - RESTRICTIONS

6. REQUEST (RESTRICTION) IS DIRECTED TO THE TRICARE HEALTH PLAN OR THE FOLLOWING PHYSICIAN/FACILITY:

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS *(Street, City, State and ZIP Code)*

c. TELEPHONE *(Include Area Code)*	d. FAX *(Include Area Code)*	7. PURPOSE OF RESTRICTION *(Optional)*

8. REQUESTED DATES OF RESTRICTION *(YYYYMMDD)*	
a. START:	b. END:

9. SPECIFY MEDICAL INFORMATION TO BE RESTRICTED *(Use back for additional space)*

SECTION III - PLEASE READ AND SIGN BELOW

I understand that:
1. The Military Treatment Facility (MTF)/Dental Treatment Facility (DTF)/TRICARE Health Plan is not required to approve this request for restriction.
2. If approved by an MTF/DTF, this restriction only applies to the MTF/DTF that granted approval. It is not transferable to other providers, MTF's or DTF's.
3. If approved, the MTF/DTF/TRICARE Health Plan is not required to abide by this restriction if the health information is needed to provide emergency treatment or services.
4. If approved, this restriction does not prevent me from having access to my own health information or to an accounting of how my health information has been used.
5. If this request for restriction is approved, the MTF/DTF/TRICARE Health Plan still has the right to use or disclose my health information under the following circumstances: judicial and administrative purposes; health oversight; research; law enforcement; public health; to avert a serious threat to health and safety; organ, eye, or tissue donation; decedents; Worker's Compensation; victims of abuse, neglect, or domestic violence; specialized government functions; and required by law.
6. Once approved, this restriction can be terminated under the following circumstances:
   a. If I request the termination in writing.
   b. If I request the termination orally and it is documented by the MTF/DTF.
   c. If the MTF/DTF/TRICARE Health Plan informs me that it has decided to terminate the restriction. In this situation, the termination only applies to the health information created or received after the termination is in effect.

10. SIGNATURE OF PATIENT/GUARDIAN	11. RELATIONSHIP TO PATIENT *(If applicable)*	12. DATE *(YYYYMMDD)*

SECTION IV - FOR PROVIDER/FACILITY USE ONLY

13. X AS APPLICABLE:	14. SIGNATURE OF APPROVING OFFICIAL
☐ REQUEST APPROVED ☐ REQUEST IS DISAPPROVED ☐ RESPONSE ATTACHED	
15. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	**SPONSOR NAME:** _____ **FMP/SPONSOR SSN:** _____ **SPONSOR RANK:** _____ **BRANCH OF SERVICE:** _____ **PHONE NUMBER:** _____

9. SPECIFY MEDICAL INFORMATION TO BE RESTRICTED *(Continued)*