REQUEST FOR RESTRICTION ON USE OR DISCLOSURE OF HEALTH INFORMATION TO A HEALTH PLAN

THE OREGON CLINIC

Please send this form to:

The Oregon Clinic Medical Records Department (ATTN: Clinical Content Manager) by:
FAX: (503) 935-8404 or **E-MAIL***: compliance@orclinic.com or **MAIL**: 541 NE 20th Ave. Ste. 225, Portland, OR 97232
Communications via e-mail are not secure

PART A: INDIVIDUAL TO COMPLETE (please print):

Name (last, first, middle): _____

Date of Birth: _____ Telephone No.: _____

Address: _____

Medical Record No.: _____

REQUEST:

I have paid out of pocket in full for the item/service and I request that The Oregon Clinic (TOC) restrict the use and/or disclosure of my health information to the following Health Plan(s):

_____

_____

Please identify the item or service that is subject to the requested restriction:

_____

_____

ACKNOWLEDGEMENT OF CONDITIONS OF RESTRICTION:

I understand that TOC is required to agree to my requested restriction(s). **The requested restriction only applies to release of information to a Health Plan for purposes of payment or health care operation, and only relates to health information for which I paid in full.** The restriction is effective (unless emergency or treatment circumstances require otherwise) until I agree to or request that the restriction be terminated.

Date: _____

Patient or Legal Representative signature: _____

Print Name of Legal Representative (if applicable): _____

PART B: TO BE COMPLETED BY COMPLIANCE DEPARTMENT:

Staff comments:

_____

_____

_____

_____

Signature of staff: _____ Date: _____

Name/Title of staff: _____

Department/Area: _____