COLUMBUS REGIONAL HOSPITAL
COLUMBUS REGIONAL HEALTH PHYSICIANS, LLC
Request for Restriction to Protected Health Information

Date of Request: ______________________________

Patient Name: ______________________________

Patient Address: ______________________________

Patient Date of Birth: ______________________________

Last 4 of Social Security Number: ______________________________

I hereby request that Columbus Regional Hospital or Columbus Regional Health Physicians, LLC (CRHP), collectively known as Columbus Regional Health (CRH) restrict the use and disclosure of my protected health information in the manner described below. If this request for restriction is granted, I understand the restriction will not apply in case of an emergency.

Please describe the restriction that you are requesting, include dates of specific health information to be restricted, and specific conditions to be restricted (please be specific): ______________________________

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I understand that CRH is not required by HIPAA to agree to the restriction requested above, unless the restriction concerns a disclosure to the health plan for purposes of carrying out payment or health care operations and such disclosure is not otherwise required by law and the restriction concerns PHI which pertains solely to a health care item or service for which CRH has been paid out of pocket by me in full. Within 30 days, a letter regarding the decision of CRH will be mailed to the address of the individual, or his or her personal representative, after review by CRH. Any accepted restriction will be effective on the date after approval of the CRH Privacy Officer. If CRH agrees to any restriction, I understand that CRH may terminate the restriction by giving me written or oral notice of the termination. The termination will be effective with respect to any protected health information created or received after the termination date indicated by CRH.

______________________________	______________________________
Signature of Patient	Date and Time
______________________________	______________________________
Signature of Responsible Party if patient is unable to sign	Date and Time
______________________________	______________________________
Signature of Witness from Columbus Regional Hospital	Date and Time

COLUMBUS REGIONAL HOSPITAL
2400 EAST 17TH STREET, COLUMBUS, INDIANA 47201
1-800-841-4938 812-379-4441
crh.org

Request for Restriction to Protected Health Information

PATIENT LABEL

OR

Patient Name: ______________________________

DOB: ________/________/________

MR #: ______________________________

Accessible Document