

**COLUMBUS REGIONAL HOSPITAL
COLUMBUS REGIONAL HEALTH PHYSICIANS, LLC
Request for Restriction to Protected Health Information (PHI)**

Patient Information

Patient Name: _____ CRH Medical Record Number: _____
 Patient Home Address: _____ Last 4 of Social Security Number: _____
 Patient Phone Number: _____ Date of Birth: _____

Restriction Request Description (Provide additional information)

Request to Restrict patient PHI to the following person or entity:

Name of Person: _____ Relationship to Patient: _____
 Name of Entity: _____ Restrict the following date of service(s): _____
 Address of Entity: _____
 Restrict the following health information from the person(s) or entity stated above: _____
 Reason for this restriction request: _____

Acknowledgment and Agreement

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.

I acknowledge and understand:

- I have the right to request restrictions on the ways in which CRH uses and / or discloses my health information.
- CRH has up to sixty (60) days to review and respond to a restriction request and will provide a written response regarding their determination regarding my restriction request.
- CRH will carefully consider the request but is not required to approve my request.
- If the request for restriction is approved, the restriction will not apply in case of an emergency or as required by federal and / or state laws.
- Any approved restriction will be effective on the date communicated to you by the CRH Privacy Officer.
- If CRH agrees to any restriction, 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.
- I must communicate my request for restriction to other healthcare providers affiliated with CRH that are involved in the services I receive, including but not limited to third party Pathologist, Radiologist, Emergency Physicians, Anesthesiologist, etc.

Patient Submission Instructions

You may submit the completed form directly to the CRH Privacy Office:

- By US mail: Columbus Regional Hospital; 2400 E. 17th Street; Columbus, IN 47201
- By e-mail: privacyofficer@crh.org

Signature of Patient / Parent / Legal Guardian

Date and Time

For CRH Internal Use Only

Request received by (CRH workforce member name): _____
 Date CRH received restriction request: _____

CRH Restriction Request Decision

Disposition of request: Approved Denied Restriction effective date: _____
 Reason for denial: _____
 Additional Comments: _____

Not a Part of the
Permanent Patient
Record

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 #: _____