DuPage Medical Group

WE CARE FOR YOU

Patient Rights Request For Restriction

PATIENT LABEL

You have the right to request restriction(s) as to how your protected health information may be used and/or disclosed to carry out treatment, payment or healthcare operations. DuPage Medical Group has the right to deny your request under certain circumstances. To exercise your right to request a restriction on the use or disclosure of your protected health information, please complete the following.

NOTE: For restrictions to a health plan for payment or health care operations, the charge must be paid in full at the time of service.

Patient Information

Patient name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Specify the protected health information to be restricted:

Date(s) of service:	Type(s) of service (lab, imaging, etc.):	Physician who provided/ordered the service:

Specify the restriction to be applied to the protected health information:

☐ DO NOT bill my insurance

☐ Other (please specify)

I am exercising my patient rights under HIPAA as stated above. I understand DuPage Medical Group may deny all or part of my request under certain circumstances. I understand DuPage Medical Group has 60 days to approve or deny my request.

Patient Signature: _____ **Date:** _____

If this request has been made on behalf of the patient, please complete the following:

Personal representative's name: _____

Personal representative's signature: _____

Relationship to patient: _____

Please fax completed form to the Coding Helpline at 630-942-7965

For DMG HIM use only

Approved ☐ Denied ☐ Date: _____ By: _____