



Request to Restrict Disclosure of Patient Health Information to Health Insurance Plans

NAME OF PATIENT _____

DATE OF BIRTH _____

I request that Westmed Medical Group not disclose my health information about the health care services listed below to (select one):

All health insurance plans: _____

The following plans (specify): _____.

I understand and agree that the restriction does not apply unless I have paid out of pocket (self-pay) for these services IN FULL at or before the time of service.

I also understand and agree that the restriction does not apply to health care services provided in connection with any complications relating to the listed services or any other health care services provided at a later date, whether or not related to the services on the list. A separate form must be completed and submitted for subsequent dates of service.

I understand that it is my responsibility to notify other providers including hospitals, laboratories, doctors, etc. of my request for restriction on the care they provide related to this service. I understand that I can reverse this decision at any time by submitting a request in writing. I understand that I am responsible for costs incurred due to me changing my mind later on. I understand that I may be required to have testing repeated and that I may be responsible for co-payments and/or deductibles due because of the required testing.

I understand that it is also my responsibility to notify other providers including hospitals, laboratories, doctors, etc. of my decision to lift this restriction. Any request to release PHI that was denied based on the restriction must be resubmitted once the restriction is lifted.

Health care services that I request not be disclosed to health insurance plans	Date of service
1.	
2.	
3.	
4.	
5.	

SIGNATURE (PATIENT OR AUTHORIZED PATIENT REPRESENTATIVE)	DATE
IF SIGNED BY PERSON OTHER THAN PATIENT, PROVIDE REASON, RELATIONSHIP TO PATIENT, DESCRIPTION OF AUTHORITY	

Please send completed form to:
Privacy Officer
Westmed Medical Group
2700 Westchester Avenue
Purchase, NY 10577

For Privacy Officer's/Designee's Use ONLY: Approved: ___ Denied: ___ Date: _____ Privacy Officer's/Designee's Signature: _____
