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| ou-logo | **The University of Oklahoma** |  |
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**Request to Restrict Use and Disclosures of Protected Health Information to Insurance Companies**

**NOTICE TO PATIENT:** Your request for a restriction on the use and disclosure of your protected health information is applicable only to the information maintained by the OU Norman Campus. If you would like to request a restriction on the use and disclosure of your protected health information maintained by any other University entity, a separate request must be submitted to that provider. (This request is applicable only to uses and disclosures by the OU Norman Campus.)

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| Last Name: | |  | | | | | First: |  | | | | Middle: | | |  | | |
| Other Names Used: | | | |  | | | Birthdate: | |  | | | | | | | | |
| Address: |  | | | | | | City: |  | | | State: | |  | | | Zip: |  |
| Home Phone: | | | ( ) | | | Alt. Phone: | | ( ) | | | Cell Phone: | | | ( ) | | | |
| Insurance Company: | | | | |  | | | Provider Name: | |  | | | | | | | |
| Member ID #: | | |  | | | | | Group/Provider ID #: | | |  | | |  | | | |
|  | | |  | | |  | |  | | |  | | |  | | | |
| Date (s) of Service Covered by Request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Service(s)/Treatment(s) Not to be Disclosed to My Insurer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I request that the above service(s)/treatment(s) not be disclosed to my insurer indicated above.  I agree to pay, or have someone pay on my behalf, for the above service(s)/treatment(s) out of pocket and in full at the time of service. I understand that if I do not, the provider will bill my insurer for the service(s)/treatment(s).  I understand my request may impact future approvals/payment for treatment by my insurer.  I understand that the above named provider is not obligated to notify other providers about the restriction, and it is my responsibility to request the restriction on disclosure from other providers, including labs and pharmacies.  I understand that this restriction does not apply to other or future service(s)/treatment(s) and that is my responsibility to request such restrictions.  I understand that the above provider will not be required to honor this restriction if required by law to release this information or if the out-of-pocket payment is not paid in full at the time of services. | | | | | | | | | | | | | | | | | |

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| **Signature of Patient, Parent, or Authorized Legal Representative\*** | |  | **Relationship to Patient** | |  | | **Date** | |

**\*May be requested to show proof of representative status**

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| FOR CLINIC USE ONLY: | | |  |  | | |  | |
| **Send Approval To:** | |  |  | **Complete All** | |  | |
| [X] | Billing |  |  |  | Payment Received at Time of Service | | |
|  |  |  |  |  | Billing Notified Not to Bill Insurance | | |
|  |  |  |  |  | Other Notified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

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|  |
| By: | | |  |  |  |  |  |
| Clinic/Department Signature |  | Title | | Date |