Request to Restrict Uses and 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.	

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

Please return form by using one of the methods listed:

- Mail to: Compliance Officer, Westmed Medical Group, 800 Westchester Avenue, Suite N-715, Rye Brook, NY 10573
- Fax: 914-719-4707
- *Email: Compliance@westmedgroup.com

**Disclaimer: Patients should carefully consider the use of email for the communication of protected health information (PHI) and should understand that there are known and unknown risks that PHI may be disclosed to, or intercepted by, unauthorized third parties. These risks include but are not limited to (i) the email being sent to the wrong person due to the sender's use of the wrong email address, (ii) e-mail service provider's ability to archive and inspect communications, and (iii) computer hacking and viruses.*

For Compliance Officer/Designee's Use Only:

Approved: ___ Denied: ____ Date: ________ Compliance Officer/Designee Signature ________________________

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