UCR HEALTH
REQUEST FOR RESTRICTION OF DISCLOSURE OF INFORMATION TO A HEALTH PLAN

Patient Name: _____ MRN: _____

Date of Service: _____ Account No.: _____

Location: _____

I hereby request that UCR Health does not disclose the following information related to the service identified above to my healthcare plan, insurance company or third party payer:

_____

_____

I understand that I am responsible for paying for this service in full for both professional and technical charges. I understand that this request applies only to the information from this service, and that I must separately request the restriction of the information on any future encounters.

I understand that UCR Health is not required to honor this request when disclosing information to my health plan, insurance company or third party for **treatment** purposes only.

I understand that this request for restricting disclosure of this information does not apply to permitted or legally required disclosures to other individuals including:

- During a medical emergency, if the information is needed to provide emergency care
- Certain public health activities
- Reporting abuse, neglect, domestic violence or other crimes
- Health oversight activities, law enforcement investigations, judicial or administrative proceedings
- Uses or disclosures otherwise required by law

I understand that the restriction request may be terminated if I request or agree to the termination in writing, or I orally agree to the termination and the oral agreement is documented.

Signature of patient or representative _____ *Date* _____

Relationship to patient (if representative): _____

Forward to: **University of California Riverside Health Correspondence, Health Information Management Department, 900 University Avenue, Riverside, California 92521.**