Texas Children's

TEXAS CHILDREN'S
REQUEST FOR RESTRICTION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patients have the right to request a restriction on disclosure of protected health information for treatment, payment, or healthcare operations. All requests to Texas Children's for restriction must be in writing and include the information documented on this form. Please attach copies of any other relevant documents that may support the restriction. If the patient is a minor child, the legally authorized representative (e.g., parent) must make the request. Texas Children's is not required to agree to all requests. Texas Children's will review each request but reserves the right to refuse the request as established by federal law. No restriction is effective until you receive written confirmation from Texas Children's.

Patient Name: _____ **Date of birth (MM/DD/YYYY):** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Phone:** _____

Requested Restriction For Electronic Sharing of Protected Health Information

☐ **Care Everywhere Sharing of Health Information:** I request that my health information no longer be shared electronically by Texas Children's through Epic Care Everywhere to all health care providers involved in my care who participates in or is connected through Epic Care Everywhere. I understand that complete medical information, including the patient's medication profile, allergies and adverse reactions may not be available at the time of care and treatment at another health care facility. This includes emergency care situations.

☐ **Care Everywhere Receiving of Health Information:** I request that my health information no longer be received by Texas Children's electronically through Epic Care Everywhere from all health care providers involved in my care who participates in or is connected through Epic Care Everywhere. I understand that complete medical information, including the patient's medication profile, allergies and adverse reactions may not be available at the time of care and treatment at another health care facility. This includes emergency care situations.

☐ **Health Information Exchange (HIE):** I request that my health information no longer be shared electronically through the Health Information Exchange to all health care providers involved in my care who participates in or is connected to the HIE. I understand that complete medical information, including the patient's medication profile, allergies and adverse reactions may not be available at the time of care and treatment at another health care facility. This includes emergency care situations.

☐ **EpicCare Link:** I request that my health information no longer be shared electronically through EpicCare Link to all health care providers involved in my care who participates in or is connected through EpicCare Link. I understand that complete medical information, including the patient's medication profile, allergies and adverse reactions may not be available at the time of care and treatment at another health care facility. This includes emergency care situations.

Request Restriction For Other Types of Sharing of Protected Health Information

☐ **Other, please provide a description of the information to be restricted**: _____

Describe how you would like the use and/or disclosure of your health information restricted: _____

_____

_____

I understand that any information that was shared before the date this form is processed will remain available to providers who request access.

A request to restrict access of protected health information, if approved, will be effective in approximately 5-7 business days after receipt by Health Information Management Office. I understand if my request is accepted, Texas Children's may make the restriction only to the extent allowable by the Health Insurance Portability and Accountability Act (45 CFR Parts 160 and 164).

I may choose to opt back into Care Everywhere, Health Information Exchange, EpicCare Link any time so that my health information may be shared with other healthcare providers. To opt back into participation in the electronic sharing of your health information, please contact the Texas Children's Health Information Management Office at releinfo@texaschildrens.org; fax to 832-825-9056; or telephone at 832--824-1600.

Texas Children's is hereby released from legal responsibility or liability for the disclosure of the records previously authorized for release. I also understand that I may revoke this opt-out request in writing at any time (except to the extent that action has been taken in reliance on this authorization) by sending a written notice to Texas Children's Health Information Management Office.

I certify that I am the Patient or Legally Authorized Representative (e.g., Mother/Father) of the Patient.

_____ **Date:** _____

Signature of Legally Authorized Representative

_____ _____

Printed Name of Patient or Legal Authorized Representative **Relationship to Patient**

Please return this completed form to the Texas Children's Health Information Management Office at releinfo@texaschildrens.org; fax to 832-825-9056; or telephone at 832--824-1600.

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