PURDUE UNIVERSITY
REQUEST FOR RESTRICTION OF THE USE OR DISCLOSURE OF PHI

Patient or Employee's Name:	Date of Birth:
Patient or Employee's Address:	
Patient or Employee's ID#:	Phone #:

I hereby request that the employees of Purdue University honor the following restrictions regarding the use and disclosure of the protected health information of the individual indicated above.

HIPAA Covered Components to which the restriction applies: (See list of Covered Components at: https://www.purdue.edu/legalcounsel/HIPAA/Covered%20Comp.html.)

Please indicate the type of disclosure to be restricted and describe the specific restriction and protected health information to which it pertains:

☐ Use or disclosure relating to treatment, payment and/or healthcare operations (refer to definitions on page 2).

☐ Use and disclosure of protected health information to a family member, other relative, or other identified person, directly relevant to this person's involvement with the individual's care or payment for health care.

☐ Use and disclosure of protected health information relating to the individual's location, general condition or death to a family member, a personal representative or other person responsible for the care of the individual.

☐ Use and disclosure relating to a person acting on the behalf of the individual to pick up filled prescriptions, medical supplies, X-rays or other similar forms of protected health information.

☐ Use and disclosure to a public or private entity authorized by law or its charter to assist in disaster relief efforts.

☐ Other uses or disclosures.

I understand that Purdue University is not required to agree to the restriction requested above and the restriction will not be effective unless the Office of Legal Counsel accepts it in writing below. If Purdue agrees to the stated restriction, Purdue may not use or disclose the protected health information in violation of the restriction except if the individual who requested the restriction is in need of emergency treatment and the restricted information is needed to provide the emergency treatment. Purdue may use the restricted information or may disclose the information to a health care provider to provide treatment to the individual and must request that the health care provider not further use or disclose the information. Any restriction agreed to by Purdue is not effective to prevent uses or disclosures permitted or required in the HIPAA Privacy Rule: disclosures to the Secretary of Health and Human Services; facility directory information; or required by law, for public health activities, about victims of abuse, neglect or domestic violence, for health oversight activities, for judicial or administrative proceedings, for enforcement purposes, about decedents, for cadaveric organ, eye or tissue donation purposes, for research purposes, for averting a serious threat to health or safety, or for specialized government functions.

I further understand that I may revoke this restriction verbally or in writing at any time by calling, mailing or delivering a revocation to: The Office of Legal Counsel, 610 Purdue Mall, West Lafayette, IN 47907, Phone 765-496-9059, Fax 765-496- 0340.

If requested by the affected individual, the revocation will be effective 2 business days after receipt by the Office of Legal Counsel.

A copy of this form will be mailed to the address of the individual, or his or her personal representative, after review. Any restriction will be effective on the date indicated below after approval of the Office Legal Counsel. If Purdue agrees to any restriction, I understand that Purdue may terminate the restriction by giving me written or oral notice of the termination. The termination will be effective with respect to any protected health information created or received after the termination date indicated by Purdue.

Signed: _____ Date: _____

_____ _____

Name of Individual or Personal Representative Relationship to Individual (if not patient/employee)

_____

Address (if other than patient's address)

☐ Restriction Accepted: _____ _____

Office of Legal Counsel Date

☐ Restriction Accepted in Part: _____ _____

Office of Legal Counsel Date

☐ Restriction NOT Accepted: _____ _____

Office of Legal Counsel Date

_____ Date Restriction Begins: _____

Printed Name

Reason NOT Accepted or Partially Accepted: _____

_____

Mail or FAX this form to: Office of Legal Counsel, 610 Purdue Mall, West Lafayette, IN 47907; FAX: 765-496-0340

Request received by the Office of Legal Counsel (date/approx. time): _____

Restriction Termination Documentation

The above restriction was requested to be terminated by _____

(entity or individual)

And was made ☐ orally, ☐ in writing. The request was initiated on _____.

The restriction will be terminated effective: _____.

☐ If box is checked, the termination only applies to PHI created or received on or after the effective date of the termination.

Use and Disclosure of Protected Health Information for Treatment, Payment or Health Care Operations

- **For Treatment:** The Health Care Providers may use and disclose your health information to provide or assist with your treatment. For example, we may provide your health information to a laboratory in order to obtain a test result important for diagnosing or treating a condition you may have.
- **To obtain payment for health care services:** We may use and disclose your health information in order to bill and collect payment for the treatment and services provided to you. For example, we may provide limited portions of your health information to your health plan to get paid for the health care services we provide to you. We may also provide your health information to our business associates who assist us with billing, such as billing companies, claims processing companies, and others that process our health care claims. We will only disclose the minimum amount of information needed to obtain payment.
- **For health care operations:** Your health information may also be used or disclosed to improve and conduct health care operations. For example, we may use your health information in order to evaluate the quality of health care services that you received, or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your health information to our auditors, attorneys, consultants, and others in order to make sure we are complying with the laws that affect us. We may also use a sign-in sheet at registration or other appropriate areas, and we may call you by name in writing and service areas.