

Texas Children's Hospital Request for Restriction of Protected Health Information

Patients have the right to request that the use and/or disclosure of their protected health information be restricted in certain cases. These are cases in which the use and/or disclosure is for treatment, payment, or healthcare operations; or when disclosure is made to others involved in the patient's care, such as a relative or friend. All requests to Texas Children's Hospital (TCH) for restriction must be in writing and include the information documented on this form. If the patient is a minor child, the legally authorized representative (e.g., parent) must make the request. TCH will review each request but reserves the right to refuse the request as established by federal law.

Patient's Name: _____ Birth Date: _____

Patient's Address: _____ Home Phone: _____

City, State, Zip: _____ Other Phone: _____

Information to be restricted: _____

Describe how the information is to be restricted: _____

To whom does the restriction apply? _____

Effective dates of restriction: Beginning date: _____ End date: _____

I wish to restrict the use and/or disclosure of my (or my child's) protected health information by TCH as described above. I understand if my request is accepted TCH may make the restriction only to the extent allowable by the Health Insurance Portability and Accountability Act (45 CFR Parts 160 and 164).

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

Address if different from the patient's above: _____

Mail or deliver this form to: Privacy Office
Texas Children's Hospital
6621 Fannin Street, MC 3-4221
Houston, TX 77030

For more information, call the Texas Children's Privacy Office at 832/824-2091.