RESTRICTION REQUEST FORM
FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

In completing this form, you are requesting the following restrictions be considered as limitations to UT Health San Antonio use and disclosure of your protected health information. If we agree to your request, we are bound by the terms of the agreement. You will be notified in writing of UT Health San Antonio's decision to accept or deny your restriction request. Until a decision is reached, your request for restriction will not be honored.

Requested Restrictions and Reason for Request:

_____

_____

_____

_____

Print Patient Name: _____

Medical Record/Account #: _____

_____ _____

Patient's Signature Date

_____ _____

Patient's Legal Representative Relationship to Patient

For UT Health San Antonio use only:

In regards to the request stated above, the UT Health San Antonio: _____Accepts ____Denies

Reason: _____

_____

_____

_____ _____

UT Health San Antonio Representative Signature Date