RESTRICITION 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

V. ICPO-03/01/2022

This is the institutionally approved form. Any alterations or customizations should be approved by the Institutional Compliance & Privacy Office.