Jefferson County Department of Health
Request for Restriction of Use and Disclosure of Protected Health Information

Patient Information

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<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Date of Birth</th>
<th>Address</th>
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<th>Medical Record Number (if known)</th>
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I request the following restrictions on the use and/or disclosure of my protected health information for treatment, payment, or healthcare operations. To restrict disclosures to your health plan you must pay for services out of pocket in full at the time of service.

I request the following restrictions on the use or disclosure of my 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 healthcare. Please include name, address, and contact information of each person.

I understand I have the right to request restriction(s) as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations, or disclosed to family members and others involved in my care. I understand that JCDH is not required to agree to the restriction(s) requested. If denied, I will generally have an opportunity to agree or object prior to disclosures made to persons involved in my care. If JCDH agrees it will be binding except in the case of emergency treatment. If restricted information is released for my emergency treatment, JCDH will request the provider not to further use and/or disclose that information.

Patient/Legal Guardian/Patient Representative Signature*  Relationship to Patient    Date

*You may be required to submit evidence of guardianship or patient representative.

If your request is denied, you may submit a written statement of disagreement to Privacy Officer, Jefferson County Department of Health, 1400 6th Avenue South, Birmingham, AL 35233 or email www.hipaaprivacyofficer@jcdh.org.

Office Use [JCDH staff fax form to (205) 930-1305 or deliver to ROI Division]

Request Received By:__________________________ (signature) Dept:____________________ Date:________________

Review Date:______________________________

Determination:

☐ Restriction Accepted  ☐ Restriction Denied  ☐ Restriction Accepted in Part  Date Restrictions Begin __________

If denied or partially accepted, reason: ________________________________________________________________

Patient Notification Method __________ Date _______ (attach communication)

Approval Signature:__________________________ Date:________________

Original on File in ROI Division
JCDH-CSD-1232-12/2023
Jefferson County Department of Health

Revocation of Restriction of Use and Disclosure of Protected Health Information

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Please read the following and complete the information requested:

☐ I revoke my previous request for restrictions of use and disclosure of my protected health information.

I understand that this revocation will not affect actions taken in accordance with my original request to restrict the use and disclosure of protected health information prior to the receipt of this written revocation. I also understand that when my restrictions of use and disclosure of protected health information indicator is removed, the restrictions previously requested will no longer be honored.

I have read the above statements and attest that I no longer require the restriction to my health information.

_____________________________ ___________________________ ______________________
Patient/Legal Guardian/Patient Representative Signature* Relationship to Patient Date

If revoked by Legal Guardian or Personal Representative, please print name: __________________________

*You may be required to submit evidence of guardianship or patient representative.

Office Use (JCDH staff fax form to (205) 930-1305 or deliver to ROI Division)

Request Received By: _______________________________(signature) Dept: __________________________Date: __________________

Review Date: ________________________________

Date Restriction Removed: ________________________________

Patient Notification Method: __________ Date: __________ (attach communication)

Signature: ________________________________ Date: __________________