

Patient Rights Request for Restriction

You have the right to request restriction(s) as to how your protected health information may be used and/or disclosed to carry out treatment, payment or healthcare operations. DuPage Medical Group has the right to deny your request under certain circumstances. To exercise your right to request a restriction on the use or disclosure of your protected health information, please complete the following:

NOTE: For restrictions to a health plan for payment or health care operations, the charge must be paid in full at the time of service.

Patient Information

Patient name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Specify the protected health information to be restricted:

Date(s) of service:	Type(s) of service (lab, imaging, etc.):	Physician who provided/ordered the service:

Specify the restriction to be applied to the protected health information:

DO NOT bill my insurance

Other (please specify): _____

I am exercising my patient rights under HIPAA as stated above. I understand DuPage Medical Group may deny all or part of my request under certain circumstances. I understand DuPage Medical Group has 60 days to approve or deny my request.

Signature of Patient or Legal Representative

Date

Relationship to Patient: _____

Please e-mail completed form to compliance@dupagemd.com or fax to 630-545-7844

For DMG HIS use only:

Date Received: _____ **Extension Necessary:** No Yes

If "Yes", provide reason: _____

Date patient notified in writing: _____

Processed By: _____