CVH-523
New 4/03

**STATE OF CONNECTICUT**
**CONNECTICUT VALLEY HOSPITAL**
**HEALTH INFORMATION MANAGEMENT**
Telephone: (860) 262-6313 Fax: (860) 262-6345
P.O. Box 351 – Middletown, Connecticut 06457

## REQUEST FOR RESTRICTIONS OF PROTECTED HEALTH INFORMATION

Patient Name _____ MPI # _____

I am requesting a restriction on the uses and disclosure of my Protected Health Information as follows:

Person or Agency: _____

Address: _____

Town: _____ State: _____ Phone: _____

**Specific Information to Restricted:**
[ ] All verbal and written documentation in my medical record
[ ] Specify: _____

_____

_____ _____
Patient Signature Date

**or**

_____ _____
Personal Representative Signature Date

Witness Signature _____ Date _____ Expiration Date: _____
(Not to exceed 1 year)

**Send Completed form to HEALTH INFORMATION MANAGEMENT**

[ ] Request for Restriction of Protected Health Information is **APPROVED**
[ ] Request for Restriction of Protected Health Information is **DENIED** Reason for Denial _____

_____

Signature _____ Date _____
Attending Psychiatrist

**Patient notified of denial of request on (date)** _____
*You have the right to have this denial reviewed by the CVH Privacy Officer.*

**CANCELLATION**:

[ ] I am requesting a termination of the above restriction.

Patient Signature: _____ Date: _____

**or**

Personal Representative Signature: _____ Date: _____

[ ] The above named patient or personal representative has verbally terminated the above restriction on (date) _____

Staff Signature _____ Title _____ Date _____

[ ] Patient/Personal Representative notified that Connecticut Valley Hospital is terminating request for the above specified restrictions for use and disclosure of Protected Health Information for the following reason(s): _____

_____

Signature _____ Date _____
Attending Psychiatrist

**ORIGINAL – Medical Record (1st page of Correspondence Section)** **COPY – Patient/Personal Representative**