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IHS-912-1 (11/06)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 11/30/2009
See OMB Statement below.

REQUEST FOR RESTRICTION(S)

45 CFR 164.522(a)

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

I request the following restriction(s) on the use or disclosure of my protected health information:

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(If Personal Representative, state relationship to patient) or Witness (if signature is thumbprint or mark)*	DATE

☐ ACCEPTED If accepted, state which of the restrictions accepted:

☐ DENIED

SIGNATURE OF CEO OR DESIGNEE	DATE

OMB STATEMENT

Public reporting burden for this collection of information is estimated to average 10 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Indian Health Service, 801 Thompson Ave., TMP Suite 450, Rockville, MD 20852, RE: PRA 0917-0030. Please DO NOT SEND this form to this address.

PATIENT IDENTIFICATION

NAME *(Last, FIrst, MI)*	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH

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