

THE UNIVERSITY OF TEXAS  
SOUTHWESTERN MEDICAL CENTER  
AT DALLAS

Ambulatory Services

**Restriction Request Form  
For Use and Disclosure of Protected  
Health Information**

Date: \_\_\_\_\_

You are requesting that UT Southwestern restrict its use and disclosure of your protected health information as described below. **Please be aware that UT Southwestern is not required to grant your request. For example, UT Southwestern may refuse any request for a restriction that could interfere with your care.** If we grant your request, we will honor the restriction, except in instances in which the information is necessary for emergency care. You will be notified in writing of UT Southwestern's decision to grant or deny your request. Until a decision is reached, your request for restriction will not be honored. UT Southwestern will respond to your request within 30 business days from the date of receipt of your request. Complete and return this form by mail to:

Privacy Officer

UT Southwestern Medical Center at Dallas  
5323 Harry Hines Boulevard  
Dallas, Texas 75390-8851

Please describe the information you wish to restrict. Please provide specific details and dates if applicable.

\_\_\_\_\_

Please describe the reason for your request.

\_\_\_\_\_

Please list the specific names, addresses and phone numbers of the persons or businesses whom you wish not to receive your health information.

\_\_\_\_\_

If we have questions in the process of evaluating your request, how may we contact you?

\_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal Guardian or Patient Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Legal Guardian or Patient Representative Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

**Office Use Only**

Request Received: Date: \_\_\_\_\_ Time: \_\_\_\_\_

Request Granted     Request Denied     Patient Notification Mailed    Date: \_\_\_\_\_

Authorization Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Copy to be retained by Privacy Office     Original to HIM:    Date: \_\_\_\_\_

Dear Patient:

You have inquired about restrictions on the use and disclosure of your health information. We want you to be aware of the impact of restricting your health information in our complex, integrated environment. UT Southwestern Medical Center at Dallas offers excellence in many different treatment specialties practicing at UT Southwestern clinics and affiliated hospitals. Your health information is stored in secure systems and is available to healthcare providers at these institutions. This access promotes timely and efficient access to your health information and allows for easy communication among healthcare providers. Approving your request may mean that your health care information will not be available in an emergency.

UT Southwestern and its affiliated hospitals recognize and value the importance of safeguarding the privacy of your health records, and we have instituted detailed procedures to protect this information, including:

- Secure areas for storage of paper medical records.
- Security measures for computerized medical records.
- Processes that grant access to medical records to those in patient-care roles and who "need to know."
- Policies for lawful release of your medical records to authorized people, businesses, or agencies.
- Individual passwords for all computer users so electronic access can be traced.
- Policies limiting medical-record access as described in the Notice of Privacy Practices.

You may request certain restrictions on the use or disclosure of your health information in the custody of UT Southwestern. **However, UT Southwestern is not required to grant your restrictions.** We have the ability to grant such requests only in limited circumstances because our treatment services and payment and healthcare operations are performed in a complex environment, and because the availability of your health information to all appropriate personnel is vital to provide you with the highest quality healthcare services.

UT Southwestern will consider carefully any request for restrictions. All restriction requests must be balanced against UT Southwestern's need to preserve the integrity of its healthcare processes and our need to prevent any interruption in delivering quality care to you, our patient.

If you would like to exercise your right to request a restriction on the use or disclosure of your health information in the custody of UT Southwestern, please complete the attached form and return it by mail to:

Privacy Officer  
UT Southwestern Medical Center at Dallas  
5323 Harry Hines Boulevard  
Dallas, Texas 75390-8851

If you would like to exercise your right to request a restriction on the use or disclosure of your health information that is in the custody of one of UT Southwestern's affiliated hospitals, please contact the particular hospital directly in accordance with the hospital's Notice of Privacy Practices.

If you have any questions, you may contact UT Southwestern's Privacy Office at 214-648-2000.

New Text