FERRIS STATE UNIVERSITY DENTAL HYGIENE
HIPAA

RESTRICTED USE OR DISCLOSURE FORM

Please check and complete either A or B, as applicable.

☐ **A. Health Plan Restriction for items/services paid for in full.**

Patient Name (please print): ____ asks the dental practice not to give information about the following items(s) and/or services(s), for which the dental practice has been paid in full, to the health plan indicated below, for purposes of payment or health care operations, unless required by law:

Items(s) or service(s): ____

Health Plan: ____

I understand that the dental practice ***must agree*** *to this requested restriction if the practice has received payment in full for these items(s) or service(s).*

Patient Signature: ____________________________________ Date: _________________________

Dental Practice: has payment in full been received? Yes/No (circle one)

Administrator's Signature:

____ Date: _________________________

☐ **B. Other Restriction**

Patient Name: ______________________________ (please print) asks the dental practice not to use or disclose the information indicated below in the manner indicated below:

Description of information:

____
____
____

Requested restricted use and/or disclosure:

____
____
____

I understand that the FSU Dental Hygiene Clinic (FSU dental practice) ***is not required*** *to agree to this requested restriction, but that if the dental practice does agree it can end the restriction by telling me. I*

understand that if the dental practice agrees to the restriction, the dental practice may use and disclose the restricted information in certain circumstances, such as for public health disclosures.

Patient Signature: ____ Date: _______________________

Administrator's Signature: ____________________________________ Date: ________________________

For Dental Office Use Only

☐ **Agree to**

☐ **Not Agree to**

Note: The dental practice must agree to a request for disclosure to a health plan of information about a health care item or service for which the dental practice has been pain in full (see Section A of this form).

Signature: ____ Date: _______________________