FERRIS STATE UNIVERSITY
University Eye Center

REQUEST FOR ADDITIONAL RESTRICTIONS

Part I: To Be Completed By Health Plan Participant, Covered Spouse, or Covered Dependent

1. Please complete the following:

Name: _____

Address: _____

Phone number: _____ Date: _____

Cell phone No.: _____

E-Mail Address : _____

Relation to Patient : _____

Social Security number: _____ Date of birth: _____

2. This request concerns:

___ My health information.

___ The health information of my minor child who is covered by the Health Plan.

Child's name: _____ Child's SSN: _____ Child's date of birth: _____

___ The health information of an individual who is covered by the Health Plan and for whom I am the legal guardian.

___ Copies of documents establishing my legal authority are attached.

___ Copies of documents establishing my legal authority are already on file with the Heath Plan

Individual's name: _____ Individual's SSN: _____ Individual's date of birth: _____

3. I request that the following additional restrictions be placed on my protected health information (please check the appropriate box):

- ☐ Restrict use or disclosure of my protected health information to carry out treatment, payment, or health care operations as follows: _____

  _____

- ☐ Restrict disclosure of my protected heath information to a family member, other relative, close personal friend or other person identified by me that is directly relevant to such person's involvement with my health care or payment for my health care services as follows: ___

  _____

- ☐ Restrict use or disclosure of my protected health information to notify or assist in notifying a family member, personal representative, or other person responsible for my care, of my location, general condition, or death as follows: _____

  _____

- ☐ Restrict use or disclosure of my protected health information to a public or private entity assisting in disaster relief efforts to notify or assist in notifying a family member, personal representative, or another person responsible for my care, of my location, general condition, or death as follows: _____

  _____

4. Signature. By signing this document, I hereby warrant that I have truthfully represented my identify and that I am authorized to make this request. I understand that if I have misrepresented my identity or my authority, that the University Eye Center ("UEC") may seek whatever criminal and civil relief is available.

I understand that the UEC may deny this request. I also understand that if the UEC agrees to this request, my protected health information may not be used or disclosed for the reasons checked above, ***except*** in the event of an emergency where I need emergency treatment and my protected health information is necessary to provide such emergency treatment. In this event, the UEC may use or disclose restricted protected health information to a health care provider in order to provide such treatment. If this information is disclosed, the health care provider will be notified that he or she must not further use or disclose such information.

Signature: _____ Date: _____

5. Submit this form to the Privacy Officer (MCO-101F).

Part II: To Be Completed By the Privacy Officer.

Received by: _____

Date received: _____

Time received: _____

Status of request: Granted: _____ Denied: _____

If denied, reason for denial: _____

Date denial notice sent (attached): _____

Request processed by: _____

Federal law requires the retention of this document and all documents concerning this matter for a period of six years, beginning on the date of the final disposition of this request.