Group Health Cooperative of South Central Wisconsin

Restriction Request for PHI

Purpose: The purpose of this form is to honor the patient's right to request restrictions to the use and disclosure of their protected health information (PHI) maintained at GHC-SCW.

__________________________ _______________________ _____________ ______________

Patient's Last Name Patient's First Name GHC # Date of Birth

____

Street Address City State Zip Code

____ ______________________________

E-Mail Address (if okay to use for this purpose) Phone Number

Brief Description of What Specific Information You Would Like to Have Restricted in Your GHC-SCW Medical Record:____

____

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Is there any other information you would like to provide or explain in more detail?__________________

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____

Do you have specific privacy concerns with related to this request? □ Yes □ No

Please elaborate (if desired):____

Can GHC-SCW do anything else to assist you with this regarding this request? □ Yes □ No

Provide additional information (if desired):____

Signature

____ _______________________________

Signature of Patient or Personal Representative Date of Signature

Upon completion of form, return to the GHC-SCW Privacy Officer using one of these options:

<u>USPS Mail</u>
GHC-SCW
Privacy Officer
1265 John Q. Hammons Drive
Madison, WI 53717-1962

<u>Fax</u>
(608) 662-4917

<u>E-Mail via PDF</u>
privacy@ghcscw.com

Please direct questions to the GHC-SCW Privacy Officer at (608) 662-4899

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