



REQUEST NOT TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I understand that _____, the Larimer County designated health care component, may use and disclose protected health information about me for purposes of health care treatment, payment, and health care operations without my consent. I also understand that the Larimer County designated health care component may use and/or disclose protected health information without my consent and/or authorization under other circumstances permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I request to restrict use and disclosure of protected health information concerning health care treatment, payment or health care operations about me by the Larimer County designated health care component in accordance with HIPAA.

The Larimer County Designated Health Care Component Is Not Required To Agree

I understand that the Larimer County designated health care component is not required to agree to this restriction.

Termination of Restriction

I understand that if the Larimer County designated health care component agrees to this restriction, either the Larimer County designated health care component or I may terminate this restriction at any time. The termination of the restriction is only effective for future uses and disclosures.

Emergency Treatment Exception

I understand that if protected health information must be used or disclosed to provide emergency treatment for me, then this restriction is void.

Questionnaire

Requestor: Please complete all of the following questions. If the question is not applicable, mark N/A on the answer line.

- (1) I request the following information be restricted [description of information]:

- (2) I request that use and disclosure of the above described information be restricted in the following manner [description of restriction]:

- (3) I request that my protected health information not be disclosed to the following individuals or entities [list individuals or entities to which information would not be disclosed]:

I understand that if a restriction is not specifically listed above and agreed to in writing by the Larimer County designated health care component, it will not be effective.

Signature _____

Date _____