OFFICE OF
HIPAA
COMPLIANCE
CENTRAL MICHIGAN UNIVERSITY

Request for Restrictions on the Use and/or Disclosure of Protected Health Information

I understand that I have the right to request a restriction or limitation on how CMU uses or discloses my health information, payment for my treatment, or for the assessment and improvement of its business and clinical operations.

I understand that CMU is **not required to agree to my request,** however, if my request is granted, CMU will comply with the request unless the information is needed for emergency treatment.

Request Date: _____

Name: _____

Address: _____

Telephone: _____

What CMU clinic does this request apply to?

_____

What information do you want to limit or restrict?

_____

_____

_____

Do you want to limit how CMU can use the information, CMU's disclosure to others, or both?

_____

_____

☐Select this box if you would like to also apply restrictions to your Electronic Medical Record.

_____ _____

Client/Patient Signature Date

_____ _____

Guardian Signature, if appropriate Relationship to Client

Please send completed form to the Office of HIPAA Compliance:

Mail to:
CMU Office of HIPAA Compliance
600 East Preston Street (Foust 005)
Mount Pleasant, MI 48859

Email to:

Send an encrypted email to hipaa@cmich.edu

If you have any questions, please call CMU Office of HIPAA Compliance at 989-774-2829.

- -

(For office use only)

___ Request Denied ___ Approved as Requested ___ Approved Per Comments

Comments:

_____
_____
_____
_____
_____
_____
_____
_____
_____

HIPAA Privacy Officer Signature:_____

Review Date: _____

Client Informed: Yes ____ No ____ Contact Date: _____

Contact method: _____