slocum

orthopedics, p.c.

Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communication

Patient Name:_____ Date of Birth:_____

Patient Address:_____ Phone:_____

Street or PO Box

_____

City State Zip

1. Who are you allowing Slocum to disclose confidential information to:_____

_____

2. Medical Information to be Communicated Confidentially:_____

_____

3. Medical Information to be restricted:_____

_____

4. Nature of Restriction:_____

_____

5. Alternative Location/Address/Telephone Number/Fax Number:_____

_____

TO OUR PATIENTS: You have the right to request restriction on the use and disclosure of your information. If you request such a restriction, we may choose to either comply with your request or terminate your care here. In certain instances, your choice to restrict the disclosure of information may invalidate your insurance coverage, and we may require that you execute both a waiver of insurance benefits and a payment agreement in order to receive care. If you have been injured on the job and have filed a workers' compensation claim, Oregon law forbids limiting disclosures to your carrier or self-insured employer.

Generally, we will not agree to requests to limit disclosure of your information related to (a) the coordination of your medical care, (b) the internal operations of our practice, or (c) legal requirements. It is simply too difficult to comply with such restrictions.

You have the right to request that we communicate certain medical information to you or someone you have allowed to receive your information in confidence. We will accommodate your reasonable written requests to receive communications of medical information by alternative means, at alterative locations and/or to allow someone you have designated to receive confidential information only if you (1) Specify the person you have allowed access to your confidential information (2) Specify the alternative location, address, telephone number or fax number and/or the alternative means of contact.

By your signature below, you acknowledge that you understand and agree to the above information.

_____ _____

Signature of patient Date

----------Below this line for Slocum Center use only----------

☐ Request for Restriction Accepted ☐ Request to Communicate Confidentiality Accepted

☐ Request for Restriction Denied ☐ Request to Communicate Confidentiality Denied

_____ _____

Signature of Slocum Center Staff Date