PAID OUT-OF-POCKET RESTRICTION REQUEST FORM FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO A HEALTH PLAN

By completing this form, you are requesting the following restrictions on disclosures of your protected health information to a health plan when you pay out-of-pocket in full for health care items or service. We are bound by this agreement.

Date of Service:_____ Name of health plan to restrict:_____

Requested restrictions and reason for request:_____
_____
_____
_____

_____ _____

Patient Name Date of Birth

_____ _____

Patient Signature Date

_____

For HeartWell LLP use only:

HeartWell LLP _____accepts _____ denies the request for restrictions to access of Protected Health Information. This determination is valid for date of service _____.

Reason:_____
_____
_____
_____
_____

Office staff signature_____date_____