Patient Name: ____________________________________
Date of Birth: _____________________________________
Medical Record Number: __________________________
(Please Print)

GUNDERSEN
HEALTH SYSTEM®

PATIENT RIGHT TO RESTRICT ACCESS TO HEALTH INFORMATION

I am requesting the following restriction to my health information:

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Purpose of Restriction Request: ______________________________________

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I understand that Gundersen Health System reserves the right to deny requests for restrictions for treatment, payment, healthcare operations or other requests.

I understand I have the right to terminate this request at any time by contacting Gundersen Health System's Privacy Office at (608) 775-7439.

Signature of Patient: ____ Date: ________________

____
(If signed by authorized person, state relationship and authority to do so.)

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FACILITY USE ONLY:
Date Request Reviewed: ______________ Name of Reviewer: ______________________________
Request above is: Approved ____________________________ Denied: ______________________
Reason for Denial: ____
Reviewer's Signature: ____ Date: _______________
DATE COPY OF FORM MAILED TO PATIENT FOR APPROVAL/DENIAL: _____________________

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FOR INTERNAL USE ONLY:
Send original to Privacy Office (Mailstop AVS-001)
Privacy Office will scan into patient's medical records under doc type: Release of Information
Date Scanned: ______________________