BAPTIST HEALTH

REQUEST FOR PRACTICE TO RESTRICT DISCLOSURE OF PROTECTED HEALTH INFORMATION TO HEALTH PLAN

Each time you receive care or treatment from a Baptist Health affiliated physician practice, a record of your care or treatment is made. Such record includes protected health information ("PHI") such as your symptoms, examination and test results and diagnoses. In order to bill your health plan for care and treatment provided to you, the practice must provide your health plan with certain PHI about you.

You have the right to request that a Baptist Health affiliated physician practice (the "Practice") not share your PHI with your health plan for specific items or services, so long as you pay for such items or services out of pocket in full. If you would like to restrict the Practice's disclosure of PHI to your health plan, you may do so by completing this form. If you would like to request a similar restriction of PHI maintained by any other Baptist Health entity, a separate request must be submitted in writing to that provider.

I request that the Practice indicated below not disclose my Protected Health Information ("PHI") to the health plan indicated below (my "Health Plan") regarding the specific healthcare item(s) or service(s) listed below, for the specific date(s) of service listed below (the "Services"):

Practice: _____

My Health Plan: _____

Services for which I'm requesting a restriction and for which I'm paying out of pocket in full:

Item or Service	Date of Service

I understand that I must pay out of pocket the full amount for the Services, and if I do not (or if my payment is denied or otherwise fails in any way) I agree that the Practice may bill my Health Plan for the Services in its usual manner (and provide my Health Plan with necessary PHI for such payment purposes). If I fail to pay any balance due within 30 days of my receipt of a bill from the Practice, I agree that the Practice may bill my Health Plan in its usual manner (and provide my Health Plan with necessary PHI for such payment purposes). I further understand that (i) **I am responsible for notifying any "downstream" providers, such as any specialist or pharmacy to which I'm referred**, and (ii) this request applies to disclosures for payment and healthcare operations purposes and does not apply to disclosures for treatment purposes or for disclosures required by law. I agree that the Practice is not responsible for disclosures made prior to its receipt of this request and payment in full, and I further understand any amounts self-paid by me will not be communicated to my Health Plan, so such self-paid amounts will not apply to any of my annual deductibles or out-of-pocket thresholds. I further understand and agree that this restriction applies to the above listed date(s) of service only and that the Practice may reference the Services provided on these dates and associated results in the medical record documentation of my future care or treatment. If I want such PHI withheld from my Health Plan, then I must submit a similar request in connection with such future care or treatment and pay for such future services out of pocket in full.

_____ _____ _____

Signature of Patient (or Name of Patient if Signed Below) | Request Date | Request Time

_____ _____

Address | Telephone

If (i) the patient is a minor, the patient's parent or guardian should consent by signing below, or (ii) if the patient is an adult but unable to consent for himself or herself, then the patient's guardian, legal representative, attorney-in-fact, surrogate or proxy should consent on the patient's behalf by signing below:

_____ _____

Signature of Representative | *Telephone*

_____ _____

Print Name | *Relationship to Patient*

Practice Use Only:

_____ _____ _____ $_____

Practice Representative | Date Received | Time Received | Amount Paid

Services Paid in Full?

□ **Yes:** Restriction Accepted
□ **Pending:** Balance Due Date _____
□ **No:** Restriction Denied