



THE UNIVERSITY OF TOLEDO  
**MEDICAL CENTER**

### Request for Restrictions of Protected Health Information (PHI)

Release of Information Unit – Health Information Management  
University of Toledo Medical Center  
1015 Research Drive, Toledo, OH 43614  
Phone: 419-383-4982 Fax: 419-383-3001

#### Patient Information

#### Restriction Response (UTMC to fill out)

Patient Name: _____ Birth Date: _____ SS# _____ Med Record # (optional): _____ Address: _____ _____ _____ Phone: _____	Date of receipt of request: _____ Your request for restriction has been: <input type="checkbox"/> Approved <input type="checkbox"/> Denied Reason: _____ Signature of UMC Privacy Officer: _____
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I request that my protected health information **not** be disclosed to: (identify individual)

For the following purposes: (treatment, payment or health care operations)

I understand that UTMC is not required to grant my request.

Please communicate the decision regarding this request to me at:

- Above stated address
- Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

*(Relationship to patient and authority to act in the patient's behalf)*

#### **Termination of Previously Granted Restriction**

The restriction set forth above is hereby terminated for the following reasons:

- Written request of the individual
- Oral request of the individual
- Written agreement of the individual
- Decision of UTMC

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of UTMC Privacy Officer