# Request for Restrictions on Uses and Disclosures of Protected Health Information

**Description: This form allows an individual to request restrictions on the way that Travis County uses or discloses protected health information.**

The Health Information Portability and Accountability Act (HIPAA) of 1996 gives you the right to request that Travis County restrict its uses or disclosures of your protected health information. To make a request for restrictions, complete this form and return it to:

***HIPAA Compliance and Privacy Office***
***700 Lavaca, Ste. 400***
***Austin, TX 78701***

You may also email a scanned form to: privacy@traviscountytx.gov.

Please note that Travis County is no required to agree to most requests and will grant such requests only if:

- The request is in writing.
- The request does not pose undue administrative difficulty.
- The request would restrict disclosure to a health plan of information that pertains solely to a health care item or service for which you have already paid Travis County in full.

**Part I: Requestor's Identity**

Name:_____

Date of Birth:_____ Last 4 of SSN: _____

Address:_____

Street City State Zip Code

Phone Number:_____Email Address: _____

If you are requesting a restriction on someone else's behalf, provide the name and address of the person on whose behalf you are filing and describe and provide proof* of your legal relationship with the individual. Recognized legal relationships include: parent of minor child, legal guardian, power of attorney, orexecutor.

Name: _____

Address:_____

Street City State Zip Code

Relationship to individual: _____

**Travis County will accept documentation such as an executed will, power of attorney, or court order. You must also furnish a valid government issued picture ID.*

**Part II: Request**

Travis County Component* that may use or disclose your protected health information:

_____

**A list of the covered components within Travis County is available from the HIPAA Compliance and Privacy Officer or on the Travis County web page **https://www.traviscountytx.gov/hipaa**.*

A description of the protected health information that I wish to restrict Travis County from using or disclosing is:

_____

_____

The uses or disclosures that I want to restrict Travis County from making to carry out treatment, payment, or health care operations are:

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**Part III: Important Information**

- Although Travis County is not required to agree to all requests for restrictions, it will review each request it receives.
- If Travis County agrees to your request for restrictions, Travis County will not use or disclose the information identified in your request unless such use or disclosure is required by law or the use or disclosure is necessary to provide you with emergency medical treatment.
- No restriction will be effective until you receive written confirmation from Travis County that your request has been granted.
- In the event that Travis County grants your request:
    - you may revoke your request at any time by completing a "Request to Terminate Restrictions" Form
    - Travis County may terminate its agreement to such restriction by informing you of its intent to do so.

**Part IV: Acknowledgment**

By signing this form, I acknowledge that, in most circumstances, Travis County is under no obligation to grant my request for restrictions. I further acknowledge that, if Travis County grants my request, the requested restrictions will not apply to the uses or disclosures described in Part III above.

_____ _____

*Signature of Requestor* *Date*

**FOR OFFICE USE ONLY**

| **OFFICE USE ONLY**<br>Date Received:_____ Received by:_____ Title:_____ | |
|---|---|
| Verification of Requestor's Identity:<br>☐ Photo ID<br>☐ Identifying Information<br>☐ Matching Signature<br>☐ Other:<br>_____ | If the request was submitted by a Personal Representative, the authority of the Personal Representative was verified by:<br><br>_____<br>Please Print Name |

| Documentation Provided: | ☐ Executed Will<br>☐ Documentation of Power of Attorney<br>☐ Signed Authorization by the Individual<br>☐ Other: _____ |
|---|---|
| Request was:<br><br>☐ Accepted<br>☐ Denied | If the request was denied, Reason:<br>_____<br>_____<br>_____ |
| Date Notice of Request Resolution Sent:_____ | |
| Signature of HIPAA Compliance and Privacy Officer: _____ | |

Termination of Restriction

_____, wish to terminate the restriction on my protected health information.

*Printed Name of Plan member or patient*

_____ _____

*Signature of Plan member, Patient or Personal Representative* *Date*