TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
EL PASO

(Patient Identification)

REQUEST: RESTRICT DISCLOSURE TO HEALTH PLAN

- I request that Texas Tech University Health Sciences Center El Paso **not** disclose my protected health information (PHI) to my health plan or other third party insurance carrier.
- **I have read the Patient Right to Restrict Protected Health Information to Health Plan form.**
- The records of the restricted services/items listed below will not be released or billed to my health plans for payment or health care operations.
- I am financially responsible for these restricted services/items and expect to pay out-of-pocket in full at the time of service for TTUHSC El Paso to accept this restriction request

Print Patient Name: _____

Print Patient Address: _____

Print Patient Phone Number: _____

Requested restriction:

Date of service: ____/ / ____ Provider of Care: _____

Services/Items to be restricted: _____

_____

Total Charge Amount (or estimated amount): $_____
(I understand that I am responsible for full charges when finalized)

Total Amount collected: _____

Signed by: _____ Date: ___/___/___ Time: ____:___ ☐am ☐pm
☐Patient ☐Parent/Guardian/Conservator ☐Representative (specify): _____

Obtained by: _____ Date: ___/___/____ Time: ____:____ ☐am ☐pm