

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: ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm	
<input type="checkbox"/> Patient <input type="checkbox"/> Parent/Guardian/Conservator <input type="checkbox"/> Representative (specify): _____	
Obtained by: _____ Date: ____/____/____ Time: ____:____ <input type="checkbox"/> am <input type="checkbox"/> pm	