SOUND INPATIENT PHYSICIANS, INC.
AND ITS AFFILIATED COVERED ENTITIES
REQUEST FOR RESTRICTIONS ON COMMUNICATIONS

PATIENT NAME:_____

BIRTH DATE:_____ SSN:_____

ADDRESS:_____

TELEPHONE:_____

By signing below, I affirm that I understand the following:

1. There are legal restrictions on the manner in which Sound may use or disclose health information about the above patient.
2. The patient or his or her authorized representative has the right to request restrictions on the way in which Sound uses or discloses my health information, in addition to the restrictions already imposed by law.
3. Sound is not required to grant my request for restrictions, unless, except, where otherwise required by law, the restriction relates to a disclosure to a health plan for purposes of carrying out payment or health care operations (and not for the purpose of carrying out treatment) and the health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.
4. If Sound grants my request for restrictions, the restricted information will not be used or disclosed except as required by law or to treat the patient in an emergency.
5. Either Sound or I can terminate our agreement to a restriction at any time by notifying the other party. If Sound terminates its agreement to a restriction, Sound will notify me and will continue to comply with the restriction for any information that was created prior to the date of termination.
6. I request the following restrictions with respect to the above patient's Protected Health Information:

_____

_____

_____

If you are not the patient, please fill out the following information:

Name:_____

Relationship to Patient:_____

Address (if different from above):_____

Telephone (if different from above):_____

Please furnish a copy of any conservator/guardianship papers with this request.

SIGNATURE:_____ DATE:_____

NOTE: *ALL REQUESTS FOR PRIVACY MUST BE SUBMITTED IN WRITING ON THIS FORM TO THE PRIVACY OFFICER AT THE FOLLOWING ADDRESS:*

Julie Seitz, Privacy Officer
Sound Inpatient Physicians, Inc.
1123 Pacific Avenue
Tacoma, WA 98422

Internal Use Only:

REQUEST IS: _____ **APPROVED** _____ **DENIED**

SIGNATURE: _____ **DATE:** _____

TERMINATION OF AGREEMENT:
DATE TERMINATED: _____
SIGNATURE: _____