REQUEST FOR RESTRICTION OF HEALTH INFORMATION

You have the right to request that Rezilient Health limit the way that we use and disclose your protected health information to carry out treatment, payment or healthcare operations. Rezilient Health is not required under the law to agree to your requested restriction unless the request is regarding a disclosure of your health information to a health plan for purposes of payment or healthcare operations and the information relates to a health care service for which you have paid out-of-pocket (Self Pay) in full.

Please complete this form if you wish to request a restriction on the use or disclosure of your health information. We will respond in writing as to approval or denial of your request. If we agree to your restriction request, we will honor your restriction unless the information is required in an emergency situation or the use or disclosure of your information is required by law.

Patient Information

Patient First & Last Name:	
Address:	Date of Birth:
City & State:	Zip Code:
Phone:	Email:

Please provide all of the following information below. Note that if we do not have all the necessary information, we may not be able to process your request.

What information do you want to limit? Please include specific dates of service or items to be restricted.

Do you want One Medical to limit our use, disclosure or both?

To whom you want the limits to apply, for example, only to you and your partner/spouse?

NOTE: Until your request has been accepted, Rezilient Health will use and disclose your health information in a manner consistent with our HIPAA Notice of Privacy Practices and applicable law.

Required Restrictions for Disclosures to Health Plans

We are required to agree to a request not to share your information with your health plan, if the following conditions are met:

1. We are not otherwise required by law to share the information;
2. The information would be shared with your insurance company for payment purposes;
3. You pay the entire amount due for the health care item or service out-of-pocket (Self Pay) or someone else pays the entire amount for you.

Examples of Restriction Requests That We Cannot Honor

- Requests restricting Rezilient Health from giving your name to an insurance company that will be asked to pay a portion of your bill.
- Requests restricting Rezilient Health from reporting your identity and condition to an agency or organization where Rezilient Health is required by law to do so.

After Rezilient has accepted a restriction, it may be terminated if:

- You request in writing that the restriction be terminated. Please address your request to 5595 Pershing Ave, St Louis, MO 63112. You may also submit this request to medicalrecords@rezilienthealth.com. Please include a copy of the original request or the patient name and date that appeared on the accepted restriction request, OR
- Rezilient Health informs you in writing that it is terminating the restriction. In this case, the termination only applies to your personal health information created or received by Rezilient Health after you have been notified of the termination.

I have read and understand the information in this Request Form.

Signature of Patient:	
Printed Name:	Date:
Signature of Authorized Representative (e.g., Parent, Legal Guardian):	
Printed Name:	Date:
Relationship to the patient/authority to act for the patient:	
Witness or Interpreter:	

Please return this completed form to Rezilient Health via one of the following methods:

1. Mail to: 5595 Pershing Ave, St Louis, MO 63112
2. Email to: medicalrecords@rezilienthealth.com

FOR INTERNAL USE ONLY

If received at Rezilient Health, please forward to the Medical Records Team.

Determination: ☐ ACCEPTED ☐ DENIED	Date of Determination:
Reviewed by Name: Title:	Date of Review: