REQUEST TO RESTRICT THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LEGAL DIVISION
SFN 1980 (6-2023)

Clear Fields

CLIENT INFORMATION

Client Name (Last, First, Middle Initial)		Date of Birth	
Previous Names Used			
Address	City	State	ZIP Code
Name of the Department Health Plan, Health Care Facility, or Program Providing Health Care			
Telephone Number (if we have questions regarding your request)			

You (or your legal representative) have the right to request that a North Dakota Department of Health and Human Services (Department) health plan, health care facility, or program providing health care, restrict the use or disclosure of your protected health information (PHI) to carry out treatment, payment, or health care operations and certain disclosures to persons involved in your care or for notification purposes. A separate request must be made to each Department health plan, health care facility, or program providing health care. The Department will respond to your request in writing within 60 days from the receipt of your request, unless you are notified in writing that an extension of up to 30 days is needed. The Department is not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan and the following applies:

- the disclosure is to carry out payment or health care operations;
- the PHI pertains solely to health care items or services for which the Department has received payment in full, on a non-sliding fee scale, for the health care items or services related to the restriction;
- the disclosure is not required by law; and
- the health care items or services are not covered by Medicaid.

Restrictions apply only to the designated record set maintained by the Department health plan, health care facility, or program providing health care. It does not apply to providers, facilities, health plans, or others outside of the Department. In case of an emergency, the Department may use or disclose the restricted PHI to provide you with emergency treatment if needed, without your authorization. The Department may need your authorization to use or disclose PHI for some services. Without your authorization, the Department may not be able to determine if you qualify for some services.

The Department may terminate its agreement to a restriction if you have requested the termination in writing or the Department has notified you in writing of its decision to terminate the restriction.

SECTION 1: REQUEST TO RESTRICT PHI FOR SELF-PAY HEALTH CARE ITEMS OR SERVICES.

Complete this section if you are requesting to restrict the disclosure of PHI to your health plan for health care items or services you will pay in full, on a non-sliding fee scale. The restriction only applies to the health plan and the health care items or services listed below.

Name of Health Plan			
Health Care Item or Service	Service Date	Name of Facility	Name of Service Provider

I UNDERSTAND THAT IN ORDER FOR THIS RESTRICTION TO BE VALID, THE ABOVE HEALTH CARE ITEMS OR SERVICES MUST BE PAID OUT OF POCKET IN FULL, ON A NON-SLIDING FEE SCALE, BY ME OR BY SOMEONE (OTHER THAN THE ABOVE HEALTH PLAN) ON MY BEHALF.

Signature of Client or Legal Representative	Date
If Legal Representative, Print Name	Relationship to Client

Requests will not be processed if signature and date are missing

SECTION 2: REQUEST TO RESTRICT PHI TO INDIVIDUALS INVOLVED IN YOUR CARE OR FOR NOTIFICATION PURPOSES. Complete this section is you are requesting to restrict the disclosure of your PHI to family members, relatives, or friends involved in your care.

Name	Relationship	PHI to be Restricted

Signature of Client or Legal Representative	Date
If Legal Representative, Print Name	Relationship to Client

Requests will not be processed if signature and date are missing

SECTION 3: REQUEST TO RESTRICT USE OR DISCLOSURE OF PHI FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. Complete this section for other requests to restrict the use or disclosure of PHI for treatment, payment, or health care operations purposes.

I request the restriction of the use or disclosure of my PHI in carrying our treatment, payment or health care operations as follows:	
Signature of Client or Legal Representative	Date
If Legal Representative, Print Name	Relationship to Client

Requests will not be processed if signature and date are missing

FOR DEPARTMENT USE ONLY

Decision
☐ Approved ☐ Approved in Part ☐ Denied ☐ Denied in Part

Comments

Date Request was Received	Date Written Notice Provided to Client

Printed Name of Department Representative	Signature	Date

TERMINATION OF RESTRICTION AGREEMENT

☐ I request the above restriction be terminated.	
Signature of Client or Legal Representative	Date
If Legal Representative, Print Name	Relationship to Client

Date Received by Department	Date Written Notice Provided to Client	
Printed Name of Department Representative	Signature	Date

☐ The Department terminates the above restriction.		
Comments		
Date Written Notice Provided to Client		
Printed Name of Department Representative	Signature	Date