FALLON PAIUTE-SHOSHONE TRIBE
FALLON TRIBAL HEALTH CENTER
1001 Rio Vista Drive • Fallon, Nevada 89406-5463
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REQUEST FOR PHI RESTRICTIONS – 45 CFR 164.522(a)

Patient Registration Form 300-8 (Rev. Apr 2023)

PATIENT NAME (FULL LEGAL NAME) _____ HEALTH RECORD NUMBER (HRN) _____

I understand that I have the right to request restrictions as to how my Protected Health Information (PHI) may be used or disclosed to carry out treatment, payment, or health care operations, or disclosed to family members and others involved in my care, and that the Fallon Tribal Health Center (FTHC) is not required to agree to the restrictions requested. Even if my request for restriction is denied, I will generally have an opportunity to agree or object prior to disclosures to persons involved in my care. If the FTHC agrees to a requested restriction, it will be binding except in the case of emergency treatment. If restricted information is released for my emergency treatment, the FTHC will request the provider to not further use or disclose that information.

I request the following restriction(s) on the use and/or disclosure of my PHI:

PATIENT/CLIENT ACKNOWLEDGEMENT

I hereby certify that I have read this form regarding the restriction of my Protected Health Information, and I am requesting that the above restrictions be implemented. I further certify that I am the patient or legally authorized by the patient to accept the terms of this form, and I know and understand the contents thereof.

SIGN HERE _____ _____

SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN DATE SIGNED

FOR OFFICIAL FTHC USE ONLY

IF ACCEPTED, STATED WHICH OF THE RESTRICTION(S) ACCEPTED:

☐ **ACCEPTED** _____

☐ **DENIED** _____

DIRECTOR/DESIGNEE SIGNATURE: _____ DATE: _____