PATIENT NAME: _____
DATE OF BIRTH: _____
UCD MEDICAL RECORD #: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone #: _____
Email (optional): _____

UNIVERSITY OF CALIFORNIA, DAVIS
MEDICAL CENTER
SACRAMENTO, CALIFORNIA

REQUEST FOR SPECIAL RESTRICTION OF PROTECTED HEALTH INFORMATION AND CONFIDENTIAL COMMUNICATIONS

I understand that UCDHS may use or disclose my protected health information (PHI) for the purposes of treatment, payment, or health care operations. UCDHS may also disclose information to someone involved in my care or the payment for my care, such as a family member or friend. I understand that UCDHS does not have to agree to my request.

I hereby request a restriction on UCDHS's use or disclosure of my PHI to the following person/entity:

_____

I want to limit the following protected health information:

_____

_____

I want to limit UCDHS's:

❒ Use of this information ❒ Disclosure of this information ❒ Both the use and the disclosure of this information

If a special restriction is agreed to, it may be terminated if:

- I request, or agree to, the termination in writing.
- I orally agree to the termination and the oral agreement is documented.
- UCDHS informs me that it is terminating the agreement. In this case, the termination is only effective for PHI created by UCDHS or received by UCDHS's after I am notified of the termination.

I hereby request UCDHS to communicate with me about my medical matters confidentially. I understand that I can request UCDHS to contact me in a certain way or at a certain location. My preferred method of confidential communications is / are:

❒ Telephone (provide your preferred phone #): _____

❒ Mail / Writing (provide your preferred address): _____

❒ Electronically (via MyChart)

Additional information (if it is applicable to your request):

_____

_____

If you believe your privacy rights have been violated, you may file a complaint with UC Davis Health System or with the Secretary of the Department of Health and Human Services, Office of Civil Rights. To file a complaint with UC Davis Health System, contact the Compliance Hotline: (877) 384-4272. You may also submit your complaint in writing and deliver to: UCDHS Compliance Department, 2315 Stockton Blvd., Sherman Way Bldg., Suite 3100, Sacramento, CA 95817.
You will not be penalized for filing a complaint.

Date	Print Name	Patient / Patient Representative Signature	Relationship to Patient