Patient Name:______________________________
Date of Birth: _____________________________
Medical Record Number: ___________________
Patient Phone Number:____________________
Patient Address: ___________________________

La Crosse, WI 54601

PATIENT REQUEST TO RESTRICT ACCESS TO HEALTH INFORMATION

I am requesting the following restriction to my health information:

____
____
____

Purpose of Restriction Request: ____
____

I understand that Gundersen Health System reserves the right to deny requests for restrictions for treatment, payment, healthcare operations or other requests.

I understand I have the right to terminate this request at any time by contacting Gundersen Health System's Health Information Management Department at (608) 775-3199 or Privacy Officer at (608) 775-6237.

Signature of Patient: ______________________________________ Date: _______________

____
(If singed by authorized person, state relationship and authority to do so.)

****
FACILITY USE ONLY:
Date Request Reviewed: ________________ Name of Reviewer: ________________________________
Request above is: Approved ______________________________ Denied: ____________________________
Reason for Denial: ____
Reviewer's Signature: ______________________________________ Date: _________________________
DATE COPY OF FORM MAILED TO PATIENT FOR APPROVAL/DENIAL: _______________________

****
FOR INTERNAL USE ONLY:
Send original to Health Information Management – Privacy (Mailstop AVS-001)
HIM Dept. will scan into patient's medical records under doc type: Release of Information
Date Scanned: ________________________