I understand that Torrance Memorial Medical Center may use or disclose my protected health information ("PHI") for the purposes of treatment, payment and health care operations. Torrance Memorial Medical Center 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 Torrance Memorial Medical Center does not have to agree to my request for a restriction.

I hereby request a restriction on the hospital's use or disclosure of protected health information **FOR THIS VISIT ONLY.** This restriction will automatically terminate when I am discharged from the hospital, after my outpatient visit or after my course of care is finished. The information I want restricted is:

☐ Make me a **"confidential"** patient. I will not receive mail, email, phone calls, visitors, clergy or deliveries (flowers, gifts, etc.) I will not be overhead paged**.** (No Publish)

☐ I wish to restrict all phone calls only. (Check box or notify your nurse after you are admitted). (Do Not Disturb).

☐ I wish to restrict clergy visits only. (Check this box or notify your nurse after you are admitted). (Visit Alert set to No Clergy).

☐ I wish to restrict the disclosure of my medical record (this visit only) from my insurance carrier. I choose to be a private pay patient for this visit. (Check this box or notify your nurse after you are admitted). (Visit Alert set to Cash Private Pay Restriction)

☐ I wish to restrict the discussion of the following condition with the listed person: (Clinical Staff)

Condition:	Person to be restricted:

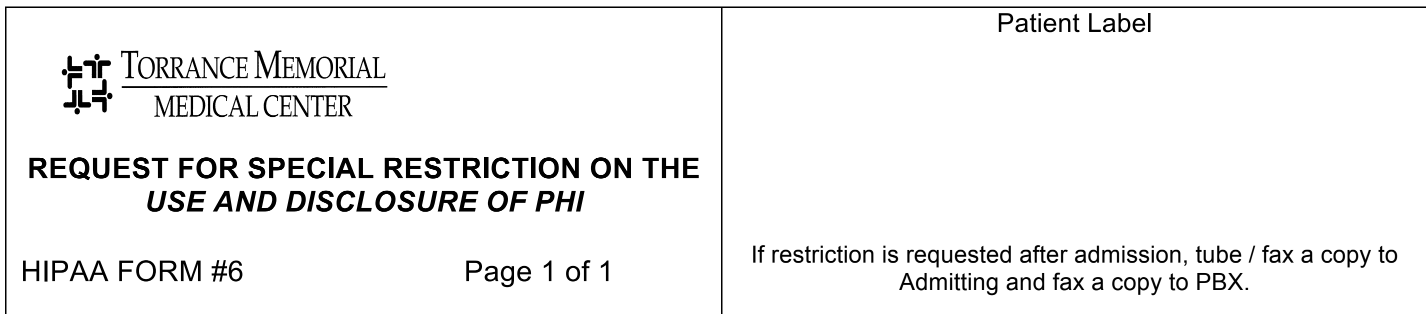
Signature of Patient or Representative:	
Print Patient Name or Representative:	
If Representative, give relationship:	Date:

Torrance Memorial Medical Center Acceptance of Restriction:

Torrance Memorial Medical Center Representative:	
Signature:	Date:

This restriction may be terminated if I orally agree to the termination and the oral agreement is documented by my nurse.

To be used after admission:		
☐ Restriction terminated	Date:	Time:
Patient Signature:	Staff Signature:	



TORRANCE MEMORIAL MEDICAL CENTER **REQUEST FOR SPECIAL RESTRICTION ON THE *USE AND DISCLOSURE OF PHI*** HIPAA FORM #6 Page 1 of 1	Patient Label If restriction is requested after admission, tube / fax a copy to Admitting and fax a copy to PBX.

Original to medical record, Copy to Admitting, Copy to PBX, Copy to Patient
Revised 6/1/09, 2/10/10