

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 understand this restriction applies only to Torrance Memorial. Torrance Memorial does not control the release of patient information from MD offices. I understand I will need to contact my physician’s office directly to make any nondisclosure requests.

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.
- I wish to restrict clergy visits only. (Check this box or notify your nurse after you are admitted).
- 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).
- I wish to restrict the discussion of the following condition with the listed person:

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:		
<input type="checkbox"/> Restriction terminated	Date:	Time:
Patient Signature:	Staff Signature:	

 <p style="text-align: center;"><b>REQUEST FOR SPECIAL RESTRICTION ON THE USE AND DISCLOSURE OF PHI</b></p> <p style="text-align: center;">HIPAA FORM #6                      Page 1 of 1</p>	<p>Patient Label</p>
--	----------------------