REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF PHI

TO OUR PATIENTS: You have the right to request that we restrict our use and disclosure of your protected health information. This means you may ask us not to use or disclose any part of your PHI for purposes of treatment, payment or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices.

Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request.

We must agree not to disclose your PHI to your health plan if the disclosure is for payment or health care operations and relates to a health care item or service which you paid for in full out of pocket. If we agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment.

We reserve the right to terminate your requested restriction if:

- You agree to termination of the restriction, either in writing or verbally; or
- You requested the termination yourself.

Patient Name: _____

Street or PO Box: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number (day): _____

1) Protected Health Information to be restricted: _____

_____

_____

_____

2) Nature of Restriction: _____

_____

_____

_____

Patient Name _____
(PLEASE PRINT)

Signature of Patient _____ **Date** _____
(REQUIRED)

Please return the completed form either by fax or by mail to:

Fax: **(800) 419-9477**
Mail: **DJO Global, Inc.**
Attn: Privacy Officer
1430 Decision St., Vista, CA 92081

THIS SECTION FOR INTERNAL USE ONLY

Request to restrict PHI has been: _____ Accepted _____Denied