IHS-912-1 (4/09)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: xx/xx/xxxx
See OMB Statement below.

REQUEST FOR RESTRICTION(S)

I understand that I have the right to request restriction(s) as to how my protected health information may be used and/or disclosed to carry out treatment, payment or health care operations, or disclosed to family members and others involved in my care. I understand that IHS may not be required to agree to the restriction(s) requested. Even if my request for restriction is denied, I will generally have an opportunity to agree or object prior to disclosures to persons involved in my care. If IHS agrees to a requested restriction, it will be binding except in the case of emergency treatment. If restricted information is released for my emergency treatment, IHS will request the provider not to further use and/or disclose that information.

I request the following restriction(s) on the use and/or disclosure of my protected health information:

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(If Personal Representative, state relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

☐ ACCEPTED ☐ DENIED	If accepted, state which of the restriction(s) accepted:
SIGNATURE OF CEO OR DESIGNEE	DATE

OMB STATEMENT

Public reporting burden for this collection of information is estimated to average 10 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Indian Health Service, 801 Thompson Ave., TMP Suite 450, Rockville, MD 20852, RE: PRA 0917-0030. Please DO NOT SEND this form to this address.

PATIENT IDENTIFICATION

NAME *(Last, Flrst, MI)*	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH