Department of Veterans Affairs

RESTRICTION OF THE RELEASE OF INDIVIDUALLY-IDENTIFIABLE HEALTH INFORMATION THROUGH NATIONWIDE HEALTH INFORMATION NETWORK (NwHIN)

Privacy Act and Paperwork Reduction Act Information: The purpose of this form is to capture your request to restrict the sharing of your electronic health information through the Nationwide Health Information Network (NwHIN).The information requested on this form is solicited under Title 38 U.S.C. Your disclosure of the information requested on this form is voluntary. However, if the information including your Social Security Number (SSN), which will be used to locate your records, is not provided completely and accurately, Department of Veterans Affairs (VA) will be unable to comply with your restriction request. VA may disclose the information that you put on the form as authorized or required by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act Systems of Records Notice identified 168VA10P2 "Virtual Lifetime Electronic Record (VLER)-VA" in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information requested to VA but if you don't, VA will be unable to process your restriction request and the sharing of your electronic health information will not be restricted. Failure to provide the requested information will not have any affect on any other benefits to which you may be entitled The Paper Work Reduction Act of 1995 requires VHA to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor and you are not required to respond to, a collection of information unless it displays a valid Office of Management and Budget (OMB) number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Purpose: Restriction of electronic exchange of individually-identifiable health information between the Department of Veterans Affairs (VA) and Non -VA Health Care Provider Organizations who are participating in the NwHIN.

Patient Full Name
Last: (print) _____ **First:** _____ **Middle:** _____

Last four digits of SSN**:** _____

RESTRICTION REQUEST:

1. You have the right to request the Department of Veterans Affairs (VA)restrict or limit the sharing of your electronic health information through the NwHIN by designating which non-VA health care provider organizations you do NOT wish to receive your information.
2. A restriction request may be filed even if you do not have an authorization on file permitting the disclosure of your health information to non-VA health care provider organizations. However, if no authorization is on file, your restriction request will be in an inactive status until such time as an authorization is filed.
3. Any restriction request you submit will ONLY apply to the sharing of your electronic health information through NwHIN.

CHOOSING YOUR RESTRICTIONS :

Indicate which non-VA health care provider organizations participating in NwHIN you do NOT wish to receive your electronic health information.

Make sure you mark all of your choices at this time and that your choices reflect all non-VA health care organizations that you wish to restrict. Once you submit your restriction request VA will not share your health information with the selected non-VA health care provider organizations through the NwHIN even if you later sign an authorization.

☐ Kaiser Permanente
☐ Med Virginia
☐ Inland Northwest Health Services
☐ Multicare
☐ South Carolina Health Information Exchange
☐ Indiana Health Information Collaborative
☐ Western New York HealtheLink
☐ Community Health Information Collaborative
☐ Utah Health Information Network
☐ North Carolina Healthcare Information and Communications Alliance
☐ _____
☐ _____
☐ _____

SIGNATURE:

1. I request and authorize VA to restrict the release of my individually-identifiable health information for treatment purposes to the selected non-VA health care provider organization(s) participating in the NwHIN. I understand in making this selection that none of my VA individually-identifiable health information will be shared with the selected non-VA health care provider organization(s) through NwHIN.

2. I understand that this restriction will remain in effect until revoked or replaced. I may revoke this restriction in writing or electronically through the eBenefits Portal, at any time, except to the extent that action has already been taken to comply with it.

3. By signing this request, I certify that this request has been made freely, voluntarily and without coercion.

4. I understand that this request supersedes and replaces all previous requests and represents completely ALL of my restriction choices.

Signature of Patient	Date
Signature of Legal Representative (if applicable) To Sign for Patient (Attach authority to sign: Health Care Power of Attorney or Legal Guardian	Date
Name of Legal Representative (please print)	Date