IHS-912-1

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 09/30/2023
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 ☐ OGC Reviewed	If accepted, state which of the restriction(s) accepted:
SIGNATURE OF CHIEF EXECUTIVE OFFICER (CEO) OR DESIGNEE	DATE

OMB BURDEN STATEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0917-0030. The time required to complete this information collection is estimated to average less than 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Indian Health Service, OMS/DRPC, 5600 Fishers Lane, Rockville, MD 20857, Attention: Information Collections Clearance Officer.

PATIENT IDENTIFICATION	NAME *(Last, First, MI)*	RECORD NUMBER
	ADDRESS	
	CITY/STATE/ZIP	DATE OF BIRTH