

**RESTRICTION REQUEST
FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)**

In completing this form, you are requesting the following restrictions be considered as limitations to UTMB's use and disclosure of your PHI. If we grant your request, we are bound by the terms of the agreement. You will be notified in writing of UTMB's decision to accept or deny your restriction request. Until a decision is reached, your request for restriction will not be honored.

Requested Restrictions:
(Please provide specific
details and dates)

Print Patient Name:

Patient Address (address
you would like to be
contacted at):

Signature of Patient or
Personal Representative:

Date:

Relationship to Patient (if
applicable):

UTMB USE ONLY

Route this form to patient Services after the individual has completed the form:
Patient Services, 301 University Boulevard, Galveston, Texas 77555-0306

UTMB: __ Accepts __ Denies

UTMB Signature: _____ Date: _____

IF PATIENT ID CARD IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

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Medical Record Form 7076-3/03
**The University of Texas Medical Branch Hospitals
Galveston, Texas**

Original-Medical Record

UTMB STRICTLY PROHIBITS CHANGES TO THIS FORM