Request to Restrict PHI from Health Insurance Company

Patient's Full Name: ____________________

Date of Birth: ____________________ UH#: ____________________

I understand that by completing this request form I am restricting my health insurance company from obtaining protected health information for the following services:

Date of Service: ____________________

Name of Test or Procedure: ____________________

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I understand that by completing this request form I am responsible for paying for the services listed above in full prior to obtaining the services.

____________________	____________	____________
Signature of Patient	Date	Time

UTMB FORMS MGT. STRICTLY PROHIBITS CHANGES TO THIS FORM

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

REQUEST TO RESTRICT PHI FROM HEALTH INSURANCE COMPANY

Health Information Management

Medical Record Form 8051–7/13
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original–Medical Record