Health Services
Request for Special Restriction on Use or Disclosure of Protected Health Information

Name ______________________________

Address: ______________________________

Birthdate: ____________________

Phone: ____________________

I understand that the Los Angeles LGBT Center (the Center) may use or disclose my protected health information for the purposes of treatment, payment, and health care operations or as otherwise authorized by me or by the law.

I understand that I have the right to request restrictions on how my protected health information is used or disclosed.

I understand that the Center is not required to approve my request, except for requests to restrict my protected health information from my insurance or health plan when I paid for those services in-full without using any health insurance or health plan benefits or coverage.

I request the following restriction to the use or disclosure of my protected health information.

1. The information I want limited is:

2. I want to limit:
   - ❑ the Center's use of this information.
   - ❑ the Center's disclosure of this information.

3. I want the limits to apply to the following person/entity/company (for example, a spouse):

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I understand that, if my request is approved, the Center may still share my protected health information in the following circumstances:

- During a medical emergency if the restricted information is needed to provide emergency treatment. However, if the information is disclosed, the Center will tell the recipient not to use or disclose it for any other purposes.
- For certain public health activities.
- For reporting abuse, neglect, domestic violence, or other crimes.
- For health agency oversight activities or law enforcement investigations.
- For judicial or administrative proceedings.
- For identifying decedents to coroner and medical examiners or determining a cause of death.
- For organ procurement.
- For certain research activities.
- For workers' compensation programs.
- For uses or disclosures otherwise required by law.

If a special restriction is approved, it may be terminated if:

A. I request the termination in writing.
B. I verbally notify Health Services staff to terminate it, and staff document the verbal request.
C. The Center informs me that it is terminating the agreement.

I understand that restrictions or termination of restrictions only apply to PHI created or received after the restriction is approved or the restriction is terminated.

____ ________________________
Signature of client (or client's personal representative) Date

____ ________________________
Printed name if signed by a personal representative Relationship to the client

You can submit this form my leaving it with any Health Services clinic front desk staff person. You can also mail it to the Los Angeles LGBT Center – Health Services, Attn: Privacy Official, 1625 Schrader Blvd., Los Angeles, CA 90028. You will get a written response in 60 calendar days.