UCLA School of Dentistry
Dental Clinics

UCLA DENTAL CLINICS
REQUEST FOR SPECIAL RESTRICTION OF USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____Date of Birth:_____

I understand and agree that the UCLA Dental Clinics may use and/or disclose my protected health information (PHI) or the PHI of the patient named above for purposes of treatment, payment, healthcare operations and other purposes as permitted or required by law.

I hereby request a restriction on UCLA Dental Clinic's use and/or disclosure of my PHI or the PHI of the patient named above.

The information I am requesting to be restricted:

_____

_____

_____

The restricted information pertains to:

Patient's visit to the (name of specific clinic or unit)_____

at the UCLA Dental Clinics on _____.

Other:_____

I request that this restriction apply to the following person/entity:_____

_____

I understand and agree that the UCLA Dental Clinics are not obligated to agree with my request. I also understand and agree that even if the UCLA Dental Clinics agree to the restriction I have requested, the information may be used and disclosed in the event (1) it is needed to provide the patient with emergency treatment; (2) it is otherwise permitted or required by law; or (3) it is used in other circumstances as described in the Notice of Privacy Practices. I also understand that even though a special restriction may be agreed to, it may subsequently be terminated if:

(1) I request or agree to terminate the restriction in a written document submitted to:

Dr. Jeffrey Goldstein, General Clinic Director
UCLA School of Dentistry
10-136 Center for the Health Sciences, Box 951668
Los Angeles, CA 90095-1668

(2) The information is needed to provide me with emergency treatment.

(3) The UCLA Dental Clinics inform me that it is terminating its agreement to restrict this information. In such situations, the termination shall only be effective for protected health information created or received by the UCLA Dental Clinics after I am notified of the termination.

_____

Patient Signature

_____ _____

Patient Name Date

OR

_____ _____

Patient's Representative Signature Relationship

_____ _____

Patient's Representative Name Date

When you have completed this form, please return it to:

Dr. Jeffrey Goldstein
General Clinic Director
UCLA School of Dentistry
Box 951668
10-136 Center for the Health Sciences
Los Angeles, CA 90095-1668

Please provide the following contact information for our response:

Address:_____

_____

Telephone:_____

Email: _____