AdvocateAuroraHealth

HIPAA Health Plan Restriction Request

I am requesting to restrict disclosure of my personal health information to my health plan for the following health care date of service/health care item: _____.

From the following Health Plan(s): _____.

I understand the following:

- If I default on my obligation to pay in full, this restriction will be null and void.
- This restriction will only restrict information disclosed to your health plan by Advocate Aurora Health Care for this service or health care item. You may need to contact the following areas that bill separately and request additional restrictions from Pharmacy, Lab, Physician, Anesthesiologist.
- If a service required preauthorization, information may have already been disclosed to my health plan.
- For related follow up services, health care providers may reference this restricted visit in their notes and restricted information may be sent to your health plan to justify payment for those future visits. Advocate Aurora Health Care will not alter or redact those notes to reflect this restriction request.
- This restriction request covers this, and only this particular visit/health care item. If follow up care is needed that you want restricted, you will need to request a separate restriction for each of those visits.
- This restriction request will not prevent any disclosures required by law.

Signature of Patient/Legal Guardian_____

_____	_____	_____	_____
Interpreter Name/ID	Language Interpreted	Date	Time