SIGNATURE MEDICAL GROUP OF KANSAS CITY, P.A.

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Patient Request to Restrict Uses and Disclosures of Protected Health Information

Federal and State law provide you the right to request restrictions on how Signature Medical Group of KC, P.A. uses and discloses your health information for treatment, payment, and health care operations or to family and friends involved in your care. For example, you can ask Signature Medical Group of KC, P.A. not to use and/or disclose the results of a blood test or a certain condition to a specific person. Signature Medical Group of KC, P.A. is not required to agree to your restriction, except when your request is that Signature Medical Group of KC, P.A. not disclose your health information to a health plan if you have paid for the health care item or service out of pocket, in full. If we agree to your restriction, we will not use or disclose your health information in violation of the restriction, unless such use or disclosure is necessary for emergency treatment, is required or permitted by law, or the restriction has been properly terminated.

To request a restriction, please complete the form below and send to:

Privacy Officer
Elise Akins
Signature Medical Group of KC, P.A.
12639 Old Tesson Road
St. Louis, MO 63128
314-842-8655 Ext.234
Eakins@signaturehealth.net

_ _

Patient Name (print):_____

Patient Address: _____

Phone Number: _____ Email: _____

Describe the restriction that you are requesting Signature Medical Group to provided, including what information you would like to restrict and to whom the restriction will apply (for example, “Do not disclose information about my biopsy to my daughter Jane Doe”):
_____
_____
_____ _____
_____
_____
_____

SIGNATURE
MEDICAL GROUP
OF KANSAS CITY, P.A.

I am requesting that Signature Medical Group of KC, P.A. provide the above described restriction of Protected Health Information. I understand that Signature Medical Group of KC, P.A. is not required to agree to this restriction, except to my health plan if I have paid for the item or service in full. I understand that it is my responsibility to restrict disclosure of any future services or items, and that it is my responsibility to notify any other health care providers to whom Signature Medical Group of KC, P.A. makes a proper disclosure for purposes of treatment.

Signature: _____ Date: _____/_____/_____

Name of personal representative (if applicable): _____

Personal representative's authority (supporting documentation required):

☐ Parent ☐ Guardian ☐ Health Care Agent ☐ Administrator/Executor
☐ Other: _____

Office Use: Received: ____/_____/_____
Completed: ____/_____/_____
Initials: _____

Payment in full for item or service received: _____