NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

PATIENT REQUEST TO RESTRICT USES AND DISCLOSURES OF PERSONAL HEALTH INFORMATION

I, _____ (Name of parent or legal guardian) hereby request that the following restriction(s) be placed on the uses and disclosures of my child's personal health information by Nationwide Children's Hospital.

Patient's Name _____ Date of Birth _____

Medical Record Number (if known) _____

Please provide a specific description of the type of restrictions you are requesting regarding how and to whom your child's personal health information is used and disclosed. Restrictions may only be requested for those uses and disclosures that relate to your child's treatment, your payment or insurance, or the business operations of Nationwide Childrens.

LIST OF RESTRICTIONS REQUESTED

Name/Department	Information requested to be restricted

I understand that Nationwide Children's is not required to agree to my restriction requests, but that Nationwide Children's is only required to attempt to accommodate reasonable requests when appropriate. I understand that I will receive a response (either in writing or by phone) within 10-14 business days of receipt of the request. I further understand that Nationwide Children's reserves the right to terminate an agreed-to restriction if it feels that termination is appropriate, and that I also have the right to terminate, in writing, any restriction by sending a termination notice to Nationwide Children's Health Information Management Department, 700 Children's Drive, Columbus OH, 43205.

_____ _____
Patient's Name Date of Birth

_____
Name of legal guardian or personal representative, if applicable

_____
Relationship to patient

_____ _____
Signature of patient, guardian, or patient's representative) Date