**CREIGHTON UNIVERSITY**
**REQUEST FOR RESTRICTED USE AND DISCLOSURE OF HEALTH INFORMATION**

This form must be completed and submitted to: University Privacy Officer, Creighton University, 2500 California Plaza, Omaha, NE 68178. Facsimiles are accepted at (402)280-3859. Scanned images are accepted at privacy@creighton.edu.

A. **Patient**. I am requesting that Creighton University amend the health record of the following patient:

**NAME** _____ **DOB** _____

**ADDRESS** _____ **SOCIAL SECURITY NUMBER** _____

B. **Record to Be Restricted**: The department whose record is to be amended (check all that apply):

❑ Creighton Dental Clinic ❑ Creighton Pediatric Therapy ❑ Creighton Specialty Pediatrics ❑ Creighton Clinic Pharmacy

C. **Requested Restriction**. I am requesting the following restriction on disclosures to the patient's health record:

_____

_____

_____

_____

D. **Expiration**. The undersigned requests that the restriction: __ expire on (insert date) _____

__ not expire.

E. **Acknowledgment**. The undersigned acknowledges the following:

- Creighton University must agree to the above request in writing before this request has any force and effect.
- If agreed upon by Creighton, the restriction shall not apply to uses or disclosures made by Creighton prior to the Effective Date.

Creighton reserves the right to terminate any agreement to restrict use/disclosure by providing you with notice of such termination. Such notice of termination shall only be effective with respect to the health information that Creighton creates or receives after the effective date of the notice of termination.

F. **Acknowledgment**. By my signature below, I acknowledge the accuracy of the information provided above.

_____ _____
Signature of Patient/ Personal Representative Date

_____ _____
Representative's Relationship to Patient (if applicable) Representative's printed name