DENVER HEALTH
REQUEST TO LIMIT THE USE OR
RELEASE OF RECORDS

Date: __________/________/________ Time: ____________________

I would like to request that Denver Health limit how it uses or releases my health information in the following ways (please describe):

____________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________

My request applies to the following records about me:
☐ Records about my care
☐ Billing and payment records
☐ Mental health records
☐ Substance abuse records
☐ Sexually transmitted disease records
☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) records
☐ Other: (specify) ___________________________
☐ All of these records

My request is for records from the following date(s): ____________________________ to ____________________________
☐ Any date I have received care

I understand Denver Health will consider my request. However, under federal law, it is not required to agree to a requested restriction. Denver Health may deny my request if it affects Denver Health’s ability to take care of me or places an unreasonable burden on its operations or information practices.

Denver Health will agree to a request to restrict disclosure of my information to a health insurance plan if the disclosure is for the purpose of payment or health care operations and is not otherwise required by law, and the information pertains solely to a health care item or service for which I have paid Denver Health for in full.

If Denver Health agrees to my request for limits, it may still use and release my records if they are needed to give me emergency care. Also, Denver Health may end this agreement in the future after Denver Health tells me that it is terminating the agreement to a restriction.

I may revoke the restrictions I place on my records at any time by telling Denver Health in writing.

_______________________________________________________________
Patient/Legal Representative  Date

_______________________________________________________________
Legal Representative’s Relationship  Date

Received by:

_______________________________________________________________
Signature and Title of Denver Health Staff  Date

Forward this completed form to the Privacy Officer at Mail Code 7776