



**REQUEST FOR HOSPITAL TO RESTRICT DISCLOSURE OF
PROTECTED HEALTH INFORMATION TO HEALTH PLAN**

Each time you receive care or treatment at a Baptist Health hospital, a record of your visit is made. Such record includes protected health information (“PHI”) such as your symptoms, examination and test results and diagnoses. In order to bill your health plan for care and treatment provided to you, the hospital must provide your health plan with certain PHI about you.

You have the right to request that a Baptist Health hospital not share your PHI with your health plan for specific items or services, so long as you pay for such items or services out of pocket in full. If you would like to restrict the hospital’s disclosure of PHI to your health plan, you may do so by completing this form. If you would like to request a similar restriction of PHI maintained by any other Baptist Health entity, a separate request must be submitted in writing to that provider.

I request that the Baptist Health hospital indicated below (*check one*, the “Hospital”) not disclose my Protected Health Information (“PHI”) to the health plan indicated below (my “Health Plan”) regarding the specific healthcare item(s) or service(s) listed below, for the specific date(s) of service listed below (the “Services”):

- | | | |
|---|--|--|
| <input type="checkbox"/> Baptist Medical Center Beaches
Jacksonville Beach, Florida | <input type="checkbox"/> Baptist Medical Center Nassau
Fernandina Beach, Florida | <input type="checkbox"/> Wolfson Children’s Hospital
Jacksonville, Florida |
| <input type="checkbox"/> Baptist Medical Center Jacksonville
Jacksonville, Florida | <input type="checkbox"/> Baptist Medical Center South
Jacksonville, Florida | |

My Health Plan: _____

Services for which I’m requesting a restriction and for which I’m paying out of pocket in full:

Item or Service	Date(s) of Service

I understand that I must pay out of pocket the full amount for the Services, and if I do not (or if my payment is denied or otherwise fails in any way) I agree that the Hospital may bill my Health Plan for the Services in its usual manner (and provide my Health Plan with necessary PHI for such payment purposes). Any amount I self-pay today is based on an estimate, and may not be the amount ultimately due for the Services. If I fail to pay any balance due within 30 days of my receipt of a bill from the Hospital, I agree that the Hospital may bill my Health Plan in its usual manner (and provide my Health Plan with necessary PHI for such payment purposes).

I further understand that (i) I am responsible for communicating any restriction request to my other health care providers involved in the Services, including, but not limited to, any physicians who participate in my care (e.g., Emergency Department physician, attending and consulting physicians, radiologists, pathologists and anesthesiologists, etc.) and any “downstream” providers, such as any home health agency or pharmacy to which I’m referred, (ii) this restriction does not cover any item(s) or service(s) rendered as a result of any complications arising from the Services, and (iii) this request applies to disclosures for payment and healthcare operations purposes and does not apply to disclosures for treatment purposes or for disclosures required by law. I agree that the Hospital is not responsible for disclosures made prior to its receipt of this request and payment in full, and I further understand any amounts self-paid by me will not be communicated to my Health Plan, so such self-paid amounts will not apply to any of my annual deductibles or out-of-pocket thresholds. I further understand and agree that this restriction applies to the above listed date(s) of service only and that the Hospital or my other healthcare providers may reference the Services provided on these dates and associated results in the medical record documentation of my future care or treatment. If I want such PHI withheld from my Health Plan, then I must submit a similar request in connection with such future care or treatment and pay for such future services out of pocket in full.

Signature of Patient (or Name of Patient if Signed Below) Request Date Request Time

 Address Telephone

If (i) the patient is a minor, the patient’s parent or guardian should consent by signing below, or (ii) if the patient is an adult but unable to consent for himself or herself, then the patient’s guardian, legal representative, attorney-in-fact, surrogate or proxy should consent on the patient’s behalf by signing below:

Signature of Representative Telephone

Print Name Relationship to Patient

Hospital Use Only:				Services Paid in Full?	
_____ PFS Representative	_____ Date Received	_____ Time Received	\$_____ Estimate	<input type="checkbox"/> Yes: Restriction Accepted	_____
				<input type="checkbox"/> Pending: Balance Due Date	_____
				<input type="checkbox"/> No: Restriction Denied	