Cornell University

Cornell Health

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Request to Restrict Disclosures of Protected Health Information to an Insurer

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") allows you to keep Cornell Health from sharing your Protected Health Information ("PHI") with your insurer when you pay for a health care item or service in full and out-of-pocket. We will honor this restriction on sharing your PHI, except when a broader use of this information is required by law or the restriction has been properly ended. To ask for a restriction on sharing PHI, please complete the form below; then give it to a Cornell Health cashier or billing office representative.

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1. **Patient/client information** (*print clearly*):

   Name _____ Date of birth (*mm/dd/yyyy*) _____

   Email address _____ Phone number _____

   Mailing address _____

2. **This section to be completed by Cornell Health cashier or billing office representative**:

Explanation of procedure/service	Date of service/visit	Provider name, notes, other comments

3. **By signing this form, I understand that:**

   - I agree to pay all estimated costs today for the services listed above, based on the standard discounted rate.
   - I agree to pay the final bill in full when I get it.
   - Only records relating to the fully paid out-of-pocket services (whether they were paid by me or someone paid them for me but not by my insurer) will be kept from my insurer.
   - If I don't make my payment(s), Cornell Health can bill and share the information with my insurer after reasonable efforts have been made to collect payment.
   - If I don't pay and Cornell Health bills my insurance, those services may not be covered by my insurer if pre-authorization was not obtained. I understand I must pay the full amount not covered by my insurer.
   - I agree that I will not submit any bills for the above services to my insurer.
   - I am responsible for alerting or asking for limits on sharing PHI with all other providers not listed above.

   I am asking that Cornell Health provide the above described limit on sharing Protected Health Information.

   Signature _____ **Date** _____ **Time** _____
   patient/client or person authorized to sign *mm/dd/yyyy* *a.m. / p.m.*

   * If the consenting party is other than the patient/client, print name and relationship to patient/client:

   _____

CORNELL HEALTH USE ONLY Received: _____/_____/_____ Completed: _____/_____/_____ Initials: _____

Please send this request to health records when complete. This request must be maintained in the patient's health record.