



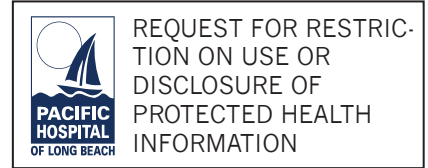
Name: _____

Today's Date: _____

Address: _____

Date of Birth: _____

Phone Number: _____



I understand that Pacific Hospital of Long Beach may use or disclose my protected health information (PHI) for the purposes of treatment, payment and health care operations. Pacific Hospital of Long Beach may also disclose information to someone involved in my care or the payment for my care, such as a family member or friend. I understand that Pacific Hospital of Long Beach does not have to agree to my request. I hereby request a restriction on the hospital's use or disclosure of protected health information. The information I want limited is:

I want to limit:

- The hospital's use of this information.
- The hospital's disclosure of this information.
- Both the use and disclosure of this information.

I want the limits to apply to the following person/entity (for example, friend or family member):

I understand that Pacific Hospital of Long Beach does not have to agree to my request.

Even if Pacific Hospital of Long Beach agrees to the restriction, it may share the information anyway in the following circumstances:

- During an emergency if the restricted information is needed to provide emergency treatment. However, if the information is disclosed during an emergency, Pacific Hospital of Long Beach will tell the recipient not to use or disclose it for any other purposes.
- Inclusion in the hospital's directory.
- For certain public health activities.
- For reporting abuse, neglect, domestic violence or other crimes.
- For health agency oversight activities or law enforce

If a restriction is agreed to, it may be terminated if:

1. I request, or agree to, the termination in writing.
2. I orally agree to the termination and the oral agreement is documented.
3. The hospital informs me that it is terminating the agreement. In this case, the termination is only effective for PHI created by the hospital or received by the hospital after I am notified of the termination.

Signature of Patient or Patient's Representative:

If Representative, give relationship: _____ Date: _____ Time: _____



NOTE: When you have finished filing out this form, please send it to Pacific Hospital of Long Beach, Attn: Correspondence – Health Information Management department, 2776 Pacific Avenue, Long Beach, CA 90806, or bring it to the Health Information Management department at Pacific Hospital of Long Beach. (Will not accept fax or copy of this form.)

For more information about your privacy rights, see the “Notice of Privacy Practices” available on our website at www.phlb.org or contact Admissions department at Pacific Hospital of Long Beach 562-997-2500 or by sending a written request to Pacific Hospital of Long Beach, Attn: Admissions department, 2776 Pacific Avenue, Long Beach, CA 90806.

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the Department of Health and Human Services. To file a complaint with the hospital, contact the Privacy Officer, 562-997-2500. All complaints must be submitted in writing. You will not be penalized for filing a complaint.