

Ohio Department of Medicaid  
**Request for Restriction of Use or Disclosure of  
 Protected Health Information (PHI)**

**FOR STATE USE ONLY**

Tracking Number
Date Received Approved
Denied By and Date

**SECTION A**

Name	Address		
Billing Number	City	State	Zip Code
Social Security Number <i>(Optional, if billing number is unknown.)</i>			

I, \_\_\_\_\_ hereby request to restrict use or disclosure of Protected Health Information (PHI) held by  
*(Name of individual)*

\_\_\_\_\_  
*(Name of covered entity, such as "ODM")*

This restriction applies to the following PHI

Reason for Request:

*If additional space is needed, please use the reverse side or attach additional pages.*

**ATTACH ANY SUPPORTING DOCUMENTATION TO THIS REQUEST. DO NOT SEND ORIGINAL DOCUMENTS.**

*(If Applicable)* Entity to which Restriction is to apply

Street Address	City	State	Zip Code
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**SECTION B**

Signature of Individual or Authorized Representative	Print Name of Individual
Representative's Legal Authority to Individual	Print Name of Authorized Representative
Today's Date	

**Distribution:** Send completed form to the Ohio Department of Medicaid, Attn:  
 ODM Privacy Official, P.O. Box 182709 Columbus, Ohio 43218-2709.

**INSTRUCTIONS**

**Section A**

- 1) "Name," "Address," and "Billing Number" of the individual for whom the restriction of PHI is requested. If the form is being completed by an authorized representative or other legal authority, enter the name and address of the authorized representative or legal authority and enter the billing number of the individual whose PHI is being amended. If the billing number is not known, enter the "Social Security Number" of the individual whose PHI is being requested.
- 2) "Name of individual" is the individual for whom the restriction of PHI is requested.
- 3) "Name of covered entity, such as 'ODM,'" is the agency or organization who has the individual's PHI.
- 4) "Restriction applies to the following PHI": describe what PHI you are requesting not be used or disclosed.
- 5) "Reason for Request": describe the reason(s) for this request.

**Section B**

The individual who is requesting the PHI restriction should sign and date the form. However, if the individual is not able to sign the form, the individual's authorized representative should sign and date it. If the form is signed by an authorized representative, the representative's "legal authority" to act on the part of the individual must be indicated. Legal authority includes but is not limited to a parent who signs the form for a minor child or an individual who has power of attorney over the affairs of the individual for which the PHI restriction is requested.