IOWA Health and Human Services

Request to Restrict Use or Disclosure of Health Information

Name of Client	Date of Request
Mailing Address – Street or P.O. Box	State ID

City, State, and Zip Code	Phone Number	Date of Birth

Email Address	Preferred Method of Communication
	☐ Email ☐ Mail ☐ Phone

Check all the programs that apply:

☐ Medicaid ☐ Hawki ☐ Woodward Resource Center

☐ Cherokee Mental Health Institute ☐ Independence Mental Health Institute

To be completed by the client or the client's personal representative

I request that the Iowa Department of Health and Human Services (Department) restrict the use or disclosure of the following health information.

I understand that the Department is not required to agree to my request, but if it does agree, the information will not be used or disclosed except as needed to get emergency treatment for me.

If I disagree with the Department decision, I may file an appeal with the Department following the directions provided to me in the decision documentation.

I understand that if my request involves issues about payment for my health care, the Department will need to know how payment for services will be made before it will agree to my request.

I would like the use and disclosure of the following health information to be restricted: _____

_____

_____

I want this information restricted because: _____

_____

Check the box that tells how you want this information to be restricted and complete the blank:

☐ I do not want this information to be given to the following persons or agencies: _____

_____

_____

☐ Other restrictions requested: _____

Client or Personal Representative Signature	Date
Representative Printed Name	Relationship to Client

To be completed by Privacy Officer

☐ Request is granted. Should the Department need to end these restrictions, you will be given written notice.

☐ Request is denied. Reason for denial: _____

Manual and Rule Reference:	
Privacy Officer Signature	Date