

You have the right to request that we restrict the use or disclosure of your protected health information, including for treatment, payment or our health care operations. We are not legally obligated to honor your request. To exercise your right to request restriction on the use or disclosure of your protected health information, please complete the following:

Specify the protected health information, the use or disclosure of which you want to restrict:

- lab results treatment information billing
- Other: (please explain): _____

State the restrictions you want to apply to that protected information: _____

Accounting of Disclosures

You have the right to an accounting of the disclosures Rush or its business associates have made of your protected health information. You are entitled to one free disclosure accounting every 12 months. To receive an accounting of disclosures please provide the dates of disclosures you want us to account for:

From: ____/____/____ **To:** ____/____/____

Amendment Request

You have the right to request that we change or amend your protected health information in the medical record that we maintain. We may deny your request in certain circumstances.

To exercise your right to request amendment, please complete the following:

Specify the records you wish to amend and the amendments you wish to make:

- lab results treatment information billing
- Other: (please explain): _____

State the reasons for the amendment request:

PATIENT'S SIGNATURE: _____ **Date:** _____

If this request is by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Personal Representative's Signature: _____

Relationship to Patient: _____