Request for Restrictions

Patient Information:			
Patient Name			Barcode #
Current Address	City	State	Zip
Last four digits of Social Security Number XXX-XX-	Phone Number	Date of Birth	

You have the right to request restrictions on the ways in which we use and disclose your health information. We will carefully consider your request, but we are not required to agree to it. If we agree to your request your information may still be shared during a medical emergency or as required by federal and state laws.

If you are requesting a restriction on disclosures to your health plan for services you have paid for out-of-pocket, the balance for those services must be paid in full at the time of your request; otherwise we are not required to honor the restriction.

I am requesting the following restriction(s):

☐ Restriction on disclosure to person or entity (*name of person or entity*): _____

☐ Other (*please specify*): _____

☐ Restriction on disclosure to health plan related to services for which I paid in full out-of-pocket: (*specify type of service and date*):

_____

If you checked "Other", we will review your request and provide you with a written response. Depending upon the nature of your request it may take several days for us to respond. Until your request has been accepted, we will use and disclose your health information in a manner consistent with our Notice of Privacy Practices and applicable law.

I understand that (1) Myriad or I may terminate this restriction at any time, (2) any request to terminate a restriction must be made in writing to the affected party before a restriction can be terminated.

Patient or Personal Representative Signature	Date
Print Personal Representative Name *(please attach applicable legal documentation)*	Relationship to Patient

Please send this form to: Privacy@myriad.com or by mail to Myriad Privacy Department, 320 Wakara Way, Salt Lake City, UT 84108

Date request received:	Reason for denial:
☐ Request accepted ☐ Request denied	
Date notification sent to patient or personal representative:	☐ Restriction updated in applicable systems
Representative name/signature	Date

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