TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™
EL PASO

(Patient Identification)

REQUEST: RESTRICT DISCLOSURE TO HEALTH PLAN

- I request that Texas Tech University Health Sciences Center El Paso **not** disclose my protected health information (PHI) to my health plan or other third party insurance carrier.
- **I have read the Patient Right to Restrict Protected Health Information to Health Plan form.**
- The records of the restricted services/items listed below will not be released or billed to my health plans for the purposes of payment or health care operations.
- I am financially responsible for these restricted services/items and expect to pay out-of-pocket, in full, at the time of service in order for TTUHSC El Paso to accept this restriction request.

Print Patient Name: ____

Print Patient Address: ____

Print Patient Phone Number:____

Requested restriction:

Date of service:_____/__ /______ Provider of Care: ________________________________

Services/Items to be restricted: ____

____

Total Charge Amount (or estimated amount): $________________
(I understand that I am responsible for full charges when finalized)

Total Amount collected:___________________________________

Signed by:________________________________Date:___/___/___Time:____:___☐am ☐pm
☐Patient ☐Parent/Guardian/Conservator ☐Representative (specify):_______________________

Obtained by:______________________________Date:___/___/____Time:____:____☐am ☐pm