Division of Services for People with Disabilities

Request for Restriction of Use and Disclosure

Mail, fax, or email to:
DSPD Records Compliance Officer
195 North 1950 West
Salt Lake City, Utah 84116
dspddocuments@utah.gov
Fax: 801-538-4279

Per the Health Insurance Portability and Accountability Act (HIPAA), you have the right to make requests on your Personal Health Information. You may request that we **NOT** share certain health information for treatment, payment, or our operations. We are **NOT** required to agree with your request if it would affect your care. To restrict the use and disclosure of your information please complete this form, have it notarized and submit it to the DSPD's records compliance officer.

Today's Date: / /	First Name:	Last Name:
Street Address:		
City:	State:	Zip Code:
Home Phone: ( ) -	Work Phone: ( ) -	
Fax *(if available)*: ( ) -	Email Address *(if available)*:	

Are you completing this request form on behalf of someone else? *(check one)*

☐ **Yes** ☐ **No**

If Yes, what is the person's name and your relationship to that person?

First Name:	**Last Name:**	**Your Relationship:**

Please be specific and describe in detail what information you would like for DSPD to restrict and to whom:

If appropriate, attach a copy of all supporting documentation to this request form.

Signature: _____ Date: ____/___/_____

Insert Notary here:

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For Internal Use Only:

Date Request Received: / /	Date Restrictions were implemented: / /
Has the request been approved: Yes ☐ No ☐	
If Yes, describe how the request will be met:	
If No, describe why the request has been declined:	
Additional comments by HIPAA Compliance Officer*(if applicable):*	
Date Request Approval/Denial Submitted: / /	

HIPAA Compliance Officer **Date**