**Limitations on Release of Medical Information from my chart**
**Patient Name:________________________________________ Date_______________**

**Limits on Release of Medical Information**

**I have read and understand your HIPAA document explaining the conditions under which you would be releasing information from my chart. I have crossed out (if necessary) any points that I do not approve prior to signing the agreement. I am herewith submitting the specific limitations and requirements to insure my privacy and accuracy of medical information released, and stipulate that only the necessary information to achieve the objective of the requesting agency or person be released and no more. This would ensure the protection not only of my own privacy but also the privacy of any other individuals who might be mentioned in your charts, and who would not be able to give consent to the release of information about them, as they would have no knowledge about it.**

1. **I wish to be contacted every time a request for information from my chart is made, prior to the release of any information. I will want to review the chart at that time, to make sure that it contains no inaccurate data. (Misunderstandings or misinterpretation of information given by patients has been reported in up to 15 percent of patient charts.)[*] After reviewing the information to be released, if any corrections were needed, I would request that they be made prior to the release of the chart. If you do not agree with me regarding the requested corrections, I would like an explanation of your reasons.**
2. **If we cannot agree on a portion of the chart material's validity, I may request either that this section not be sent, or that I be allowed to insert a statement about this information, which will be kept in the chart as a part of my permanent medical record. (For further information on my right to do this, see www.hhs.gov/ocr/hipaa).**
3. **I request that a notation be made on the cover of my chart stating that "Patient must be contacted before any information is released from this chart- see "Limitations on Consent to Release Form," so that if there is a change in staff, this request is not overlooked.**

**Thank you for your consideration in this matter. By signing below, I know that you have consented to implement this policy as recommended by the U.S. Department of Health and Human Services Office for Civil Rights.**

____________________________________________________________

**Physician/Practitioner Signature Date**

[*] SUBMITTED BY: INA Task Force on Patient Safety/Medical Errors Economic and General Welfare Commission