CTOA CENTRAL TEXAS OB/GYN ASSOCIATES

REQUEST FOR RESTRICTION OF PROTECTED HEALTH INFORMATION

Name_____

Acct#_____DOB_____

I acknowledge:

- I have insurance coverage.
- The services that I receive may or may not be covered by my insurance plan.
- I am specifically requesting that a claim **NOT** be filed for _____ (date of service) services.
  (If there are multiple visits, the patient must request this form for each applicable DOS)
- I agree to pay for these services, in full at the time of service.
- I am requesting that the above referenced services should NOT be released / disclosed to anyone without my specific consent.

Signature Date

*(**Staff:** Change the Visit Ins Cov drop down from Primary to **N/A** at the Visit Information: Check-in screen)*