



REQUEST FOR FURTHER RESTRICTIONS

Use this form to make a request that Cook County Health (CCH) agree to additional restrictions on how we use and disclose your Protected Health Information (PHI). We call this a "Further Restriction Request."

1. You may request that CCH apply additional restrictions on how we use and disclose your PHI for treatment, payment, or healthcare operations, and for uses and disclosures of your PHI to family and friends involved in your care or involved in the payment for your care. HIPAA permits you to make a request, but it does not require us to agree to your request. More details about these requirements are outlined in our Notice of Privacy Practices.
2. You may request CCH to restrict the disclosure of your PHI to a health plan for purposes of carrying out payment or healthcare operations, if the PHI pertains only to a healthcare item or service for which CCH has been paid out of pocket in full. If your request meets these requirements, CCH must comply with this request. Please note that this restriction will not apply to disclosures made for treatment purposes.

For CCH to respond promptly and accurately to your Further Restriction Request, please complete this form in its entirety.

Individual Last Name			Individual First Name			Individual Middle Name		
Birth Date	Month	Day	Year	Today's Date	Month	Day	Year	
Address			City	State	Zip	Phone		
REQUESTED RESTRICTION Please describe in detail how you would like for CCH to further restrict the use and disclosure of your PHI.								
REASON FOR FURTHER RESTRICTIONS REQUEST Please specify the reason(s) for your Further Restriction Request.								
Signature of Individual				Date				
FOR PERSONAL REPRESENTATIVES OF THE PATIENT								
Name of Personal Representative				Relationship to Individual				
<i>I hereby certify that I have the legal authority under applicable law to make this request on behalf of the individual identified above.</i>								
Signature of Personal Representative				Date				
Please return this form to this address. Or, call this number with questions: 1-877-476-1873			Ashley Huntington, JD, CHC Privacy Officer 1950 W. Polk Street, Suite 9217 Chicago, IL 60612			Place Patient Label Here		
Form Updated: June 2026 2026-06 Request Restrictions - Form								