Please check and complete either A or B, as applicable.

☐ A. Health Plan Restriction for items/services paid for in full.

Patient Name (please print): ________________________________ asks the dental practice not to give information about the following items(s) and/or services(s), for which the dental practice has been paid in full, to the health plan indicated below, for purposes of payment or health care operations, unless required by law:

Items(s) or service(s): ________________________________________________________________

Health Plan: ________________________________________________________________________

I understand that the dental practice must agree to this requested restriction if the practice has received payment in full for these items(s) or service(s).

Patient Signature: ________________________________ Date: ______________________________

Dental Practice: has payment in full been received?  Yes/No (circle one)

Administrator’s Signature: ________________________________ Date: ______________________________

☐ B. Other Restriction

Patient Name: ________________________________ (please print) asks the dental practice not to use or disclose the information indicated below in the manner indicated below:

Description of information:
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Requested restricted use and/or disclosure:
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

I understand that the FSU Dental Hygiene Clinic (FSU dental practice) is not required to agree to this requested restriction, but that if the dental practice does agree it can end the restriction by telling me. I
understand that if the dental practice agrees to the restriction, the dental practice may use and disclose
the restricted information in certain circumstances, such as for public health disclosures.

Patient Signature: __________________________________________ Date: ______________________

Administrator’s Signature: _________________________________ Date: ______________________

_____________________________________________________________________________________

For Dental Office Use Only

☐ Agree to

☐ Not Agree to

Note: The dental practice must agree to a request for disclosure to a health plan of information about a
health care item or service for which the dental practice has been paid in full (see Section A of this
form).

Signature: __________________________________________ Date: ______________________