

REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF PHI

TO OUR PATIENTS: You have the right to request that we restrict our use and disclosure of your protected health information.

We do not have to agree to your requested restrictions. However, if we do agree to the requested restriction, we will abide by the restriction unless a medical emergency requires otherwise.

We reserve the right to terminate your requested restriction if:

- You agree to termination of the restriction, either in writing or verbally; or
- You request the termination yourself.

Patient Name: _____

Street or PO Box: _____

City: _____

State: _____

Zip: _____

Phone Number (day): _____

Phone Number (night): _____

1) Protected Health Information to be restricted: _____

2) Nature of Restriction: _____

Patient Name

Signature of Patient

Date

Request to restrict PHI has been:

_____ **Accepted**

_____ **Denied**