

Request for Restrictions on Use and Disclosure of Health Information

Identification

| | | | | | |
|-----------------------------------|--|----------------------|----------------------------------|--------------------|-----|
| Member Name: _____ | | Date of Birth: _____ | | Member ID #: _____ | |
| Member Address: _____ | | _____ | | _____ | |
| Street | | Apt # | City | State | Zip |
| Member Home Phone #: (____) _____ | | | Member Wk. Phone #: (____) _____ | | |

Request

I understand that I may request restrictions on specified uses and disclosures of my health information. As such, I hereby request restriction of the use and disclosure of my health information that is created or maintained by this company in the following circumstances:

Signature Date

Personal Representative Authority

This Section for Company Use Only

Request APPROVED

- | | |
|-----------------------|---|
| Company Requirements; | <input type="checkbox"/> Notification to staff of restrictions |
| | <input type="checkbox"/> Notification to other person(s), as needed |

Request DENIED

- | | |
|--------------------|---|
| Reason for Denial: | <input type="checkbox"/> May prevent or delay effective treatment |
| | <input type="checkbox"/> Disclosure required by law |
| | <input type="checkbox"/> Other |

By: _____

Staff Title Date