Personal Health Information Disclosure Restriction Request

The purpose of this form is to document specific instances where disclosure of protected health information has been requested to be restricted by the individual.

Date: ____________________

Information on Person Requesting Restriction

Patient Name: ______________________________________ Date of Birth: __________________

Medical Record/Set: ____

Reason for Restriction: ____

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Please describe what information you wish to restrict from disclosure: _______________________

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Access should be denied to the following individual(s):

Name: ____ Relationship: ______________________

Name: ____ Relationship: ______________________

Name: ____ Relationship: ______________________

Name: ____ Relationship: ______________________

We have the right to revoke this restriction at any time. The termination of the restriction will only be effective for protected health information received or created after we inform you that the restriction has been revoked.

____ ____________________

Signature of Patient or Legal Patient Representative *Date*