

Request For Restriction

Name: _____ Social Security Number: _____

Primary Physician: _____ Date of Request: _____

I hereby request that you restrict the disclosure of my health information to the following individual(s) or healthcare provider(s). In accordance with the HIPAA Privacy Rule (Section 164.522), I am permitted to request this restriction of use or disclosure of my protected health information.

[Please provide specific instructions regarding the information that you wish to restrict and the individual(s) to whom we should restrict access to your protected health information]

Effective Date of Restriction: _____ Date Restriction is Terminated: _____

Patient Signature: _____

Signature of Guarantor: _____
(Sign If Patient Is A Minor)

(Office Use Only)

Date received by Site Compliance Contact/Office Manager: _____

Date Request is Accepted: _____

Prepared by: _____

Sent by: Mail Courier UPS Certified

Verbal Discussion: _____ Date: _____
(Staff signature)

Date Restriction Request Denied: _____

Date response sent to patient: _____

Denial Prepared by: _____