PATIENT REQUEST FOR RESTRICTIONS ON PROTECTED HEALTH INFORMATION (PHI) USE & DISCLOSURE

Patient Name:

Patient Address: MM / DD / YY

Medical Record #: Date Of Birth:

Other Identifier (Social Security Number):

Please consider this a request for me to exercise my rights under federal and state laws to request confidential communication of my protected health information.

Please explain below how, specifically, you want the **use** of your protected health information restricted **IN OUR PRACTICE**:

A. **WHAT** information do you want restricted?

B. **WHO** is restricted from accessing this information?

Please explain below how, specifically, you want your protected health information restricted from **DISCLOSURE TO OUTSIDE ENTITIES**:

A. **WHAT** information do you want restricted (not disclosed)?

B. **WHO** is restricted from accessing this information?

I understand that the physician (or provider) to whom I am making this request will make reasonable efforts to accommodate this request. I understand that the physician (or provider) is not required to honor this request when information about me is needed for emergency treatment, or in various instances when the information is permitted, by law, to be released. I further understand that the physician (provider) may terminate this restriction and I will be informed of the termination. I may also choose to terminate this restriction and may do so orally or in writing.

Date:	Patient Signature:

FOR OFFICE USE ONLY

Date	Action	Initials	Notes
	This request reviewed		
	This request granted		
	This request denied		Reason for denial:
	Denial (in writing) sent to patient		(attach copy)
	This request terminated by patient		
	This request terminated by physician (provider)		
	Patient notified of terminiation		(attach copy)