



REQUEST FOR LIMITATIONS AND RESTRICTIONS OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Patient SSN: (last 4 digits) \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_

\_\_\_\_\_

Under the Health Insurance Portability and Accountability Act of 1996 we may disclose medical information about you to people who may be involved in your medical care such as therapists, family members, clergy, or other persons that are part of your care. You have the right under the Health Insurance Portability and Accountability Act of 1996 to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request limitations and restrictions, you must complete this form and return it to us.

Please describe as specifically as possible the type of information that you would like for us to restrict or limit. \_\_\_\_\_

\_\_\_\_\_

- All information in EHR Appointments Diagnostic test results

Please describe as specifically as possible how you would like this information to be restricted or limited. \_\_\_\_\_

\_\_\_\_\_

Table with 3 columns: Name, Relationship, Phone. Rows for sharing information.

Signature of Patient or Legal Guardian Date

For Use by the Center only: Date Received Request Has Been: Accepted Denied

Comments: \_\_\_\_\_

Practice Manager/Office Coordinator Date entered into EHR