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._____

_____

May only share with

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____

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