_____

REQUEST FOR FURTHER RESTRICTIONS

Please use this form to request that _____ place additional restrictions on the use and disclosure of your protected health information. You may request further restrictions as to the use and disclosure of your protected health information for treatment, payment, or health care operations, and the use and disclosure to family and friends. HIPAA Privacy Rules permits you to submit this request, however, _____ is not required to agree to such request.

Today's Date: __/__/_____

Patient Name:
Birthdate:
Address (address, city, state, zip code):
Phone:
E-Mail Address:
REQUESTED RESTRICTION/APPROVED PARTIES:
REASON FOR RESTRICTIONS REQUESTED:
You may end the restriction at any time by notifying us in writing. Under some circumstances, we will have the right to revoke the restriction without your consent. In such case, you will receive prior notification from us of the revocation of the restriction. In such cases where prior notification to you is not possible, we will use or disclose your restricted information as authorized or required by law.
Signature of Patient or Personal Representative : _____
Date: _____
Name of Personal Representative: _____ Relationship to Patient:_____
(I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.)
Please return this form to : _____ _____

_____
FOR OFFICE USE ONLY: Date Received: _____ Completed by: _____
Approved or Denied: _____