



**Request to Restrict Use and Disclosure of Protected Health Information (PHI)**

**Section A: Patient (or representative) to complete the following information**

Date \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Patient \_\_\_\_\_  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_

**Information Restriction**

I am requesting a restriction on the use/disclosure of my protected health information in the manner described below. I understand that The Care Team may deny this request. If my request is approved, I understand that the restriction will not apply in cases where I need emergency treatment.

Restrictions for Treatment, Payment or Operation will only apply for visits/encounters that were paid for in full by me; out of pocket.

Description of Specific Health Information to be Restricted:  
\_\_\_\_\_  
\_\_\_\_\_

Persons/Organizations Restricted from Use/Disclosure: \_\_\_\_\_  
\_\_\_\_\_

Other Restrictions (please specify):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Signature of Patient or Personal Representative

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Date

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Print Name

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Personal Representative relationship to patient

***Section B: The Care Team to complete the following information***

**Your request for restriction has been:**

Accepted\*

Denied

*\*In the case of an emergency or when necessary to comply with the law, we may use and disclose your health information despite the restrictions requested herein until you terminate these restrictions.*

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Signature of the Compliance Manager

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Date

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Print Name

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**Section C: The Care Team and the Patient, if possible, complete this section**

**Termination of Restriction**

The above named patient agreed to terminate this restriction on:

\_\_\_\_\_

The above named patient was notified on \_\_\_\_\_ (date) that this restriction was terminated. Patient was notified:

In person

By telephone (attach documentation)

By Mail (attach documentation)

\_\_\_\_\_  
Signature of The Care Team Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
If possible, Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Personal Representative relationship to patient

\_\_\_\_\_  
*Distribution of copies: Original to individual's record, copy to individual*