Patient Request for Restrictions of PHI

Clinic Name, Address & Phone Number

Client's Name: _____ Date of Birth: _____

Address: _____

Phone number (if questions about your request for restrictions): _____

Instructions: Please complete this form and submit to the front desk. The Center's Privacy Officer or the Privacy Officer's designee will review your request to determine if the Center is able to honor the request. Not all requests can be honored. You will be informed within five (5) business days as to whether your request can be honored.

I am requesting the following restrictions on the use and/or disclosure of my information:
Check all that apply and complete the additional information for that section(s).

□ ALTERNATE CONTACT METHODS

I request to receive mail at the following alternate address: _____

_____

□ RESTRICT DISCLOSURE TO SPECIFIC COMPANY OR PERSON

I do NOT want my information disclosed to the following company or person: _____

_____

_____

Issue or Concern about the disclosure: _____

□ RESTRICT DISCLOSURE FOR A SPECIFIC USE

I do NOT want my information disclosed for the following purposes: _____

_____

_____

□ RESTRICT DISCLOSURE TO MY INSURANCE COMPANY

I do NOT want to file a claim with my insurance company for services received at this office on _____.
Date

I understand that I must pay my bill in full at the time of service in order to exercise my right to restrict disclosure to my insurance company.

□ OPT-OUT OF RESEARCH POOL

I do NOT wish to be contacted regarding participation in any research projects.

_____

Signature of Client or Authorized Representative Date signed

_____

Relationship to Client