You have the right to request restrictions on how this practice makes certain uses and disclosures of your personal health information for treatment, payment and healthcare operations. Please note that this practice is not required to grant your request to restrict use and disclosures. If this request is approved, it shall not apply if the information for which you request to limit is required to provide emergency treatment to you.

Patient Name:	Social Security/MRN:
Date of Birth:	Phone Number:
Street Address:	City, State, Zip Code:

Please describe in detail the type of information you would like to limit:

Please specify whether you would like to limit the following:

☐ Practice Uses of the above specified information

☐ Practice Disclosure of the above specified information

☐ Both the Use and Disclosure of the above specified information

To whom would you like these limits to apply?

☐ Parent(s) Identify _____

☐ Spouse Identify _____

☐ Children Identify _____

☐ Guardian Identify _____

☐ Other Identify _____

Describe: _____

Parent/Guardian Signature: _____ Date: _____

(If other than patient, cite authority and attach proof if applicable: _____)

Internal use only:

☐ Granted ☐ Denied

Reason for Denial: _____

_____

Completed By: _____ Date: _____