[Insert Letterhead]

**Request for Restrictions on Uses and Disclosures of Protected Health Information**

I hereby request that [Insert Covered Entity name] restrict the use and disclosure of my health information as described below.

**Name of Patient (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Record Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Description of restriction**:

|  |
| --- |
|  |
|  |
|  |
|  |

**Patient Rights**: I understand I have the right to request a restriction on how my health information is used and/or disclosed. My request may ask for restrictions on the uses and disclosures of my protected health information to disclosures to a family member, relative, close friend, or any other person involved in my care or the payment for my care; as well as, disclosures of my information for notification of my location, general condition, or health. I understand a restriction will not apply to my information being used in treatment, payment, and health care operations. I understand that my request must be in writing.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature |  | Date |
|  |  |  |
|  |  |  |
| Relationship To Patient if Signed By Legal Representative |

If you have any questions regarding restrictions of your health information, please contact the Privacy Officer.

|  |
| --- |
| **This section is for [Insert Covered Entity name] use only.** |
| The above request for restriction of health information has been: |  | Granted |  | Denied |
|  |
| Reason(s) for denial, if applicable: |
|  |
|  |
|  |
| Signature of Privacy Officer |  | Date |
|  |  |  |