REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION

Patient Name_____Phone_____

Patient Address_____
(Street) (City) (State) (Zip)

Medical Information to be Restricted_____

_____

_____

Nature of Restriction_____

_____

_____

Medical Information to be Communicated Confidentially_____

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_____

Alternative Location/Address/Telephone Number_____

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_____

NOTICE TO PATIENTS
You may request that we restrict our use and disclosure of your medical records and information. Although the law does not require us to agree to your requested restrictions, if we do agree to the requested restriction, we will abide by the restriction unless a medical emergency or law requires otherwise. You also have the right to request that we communicate certain medical information to you in confidence. We will accommodate your reasonable written requests to receive communications of medical information by alternative means or at alternative location only if you (1) specify the alternative location, address or telephone number and/or the alternative means of contact and (2) agree to be responsible for an explain how payment will be handled for any additional costs associated with the alternative method of communication. This restriction or release to communicate is valid for three (3) years from the date signed.

By your signature below, you acknowledge that you understand and agree to the above information.

Patient
Signature_____Date_____

- ☐ Request for Restriction **Accepted**
- ☐ Request for Restriction **Denied**
- ☐ Request to Communicate Confidentially **Accepted**
- ☐ Request to Communicate Confidentially **Denied**

This Request for Restriction and Confidential Communication Form is to be made part of the medical record of:

_____ Date_____ Approved by_____