

Request for Restrictions on Use and Disclosure of Health Information

**Identification**

Member Name: _____	Date of Birth: _____	Member ID #: _____			
Member Address: _____	Street	Apt #	City	State	Zip
Member Home Phone #: (____) _____	Member Wk. Phone #: (____) _____				

**Request**

**I understand that I may request restrictions on specified uses and disclosures of my health information. As such, I hereby request restriction of the use and disclosure of my health information that is created or maintained by this company in the following circumstances:**

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\_\_\_\_\_

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Personal Representative Authority

**This Section for Company Use Only**

**Request APPROVED**

- Company Requirements;  Notification to staff of restrictions  
 Notification to other person(s), as needed

**Request DENIED**

- Reason for Denial:  May prevent or delay effective treatment  
 Disclosure required by law  
 Other

By: \_\_\_\_\_  
Staff Title Date