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REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION

PATIENT NAME: ______________________________ DOB: ____________

I DO HEREBY LIMIT ACCESS TO MY MEDICAL RECORDS AS FOLLOWS:

List of Information Restricted:
( ) My entire medical records
( ) Portions of my records detailed here:
____
____
____

List of Persons or Entities Prohibited:
____
____
____
____

____ ________________
Patient's Signature or Representative Date

____ ________________
Printed Name of Patient Representative Relationship

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FOR OFFICE USE ONLY

Date: ____________ Describe what limitations were denied: ______________
____
____

Date: ____________ Describe what limitations were accepted: ____________
____
____

Date: ____________ Name of Business Associates notified of accepted Limitations:
____
____

This form shall be placed in the patient's medical records.

Revised August 20, 2013