REQUEST FOR RESTRICTIONS ON
USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Birth Date: _____/_____/____
MM / DD / YR

Address:

Home Telephone Number: E-mail:
Patient Identification Number and/or Social Security Number:

I, _____ am requesting a restriction on Orchidia Medical Group use and/or disclosure of my health information in the manner described below. I understand that Orchidia Medical Group may deny this request. I also understand that if agreed to, Orchidia Medical Group may not be able to honor this request if I require emergency treatment.

Description of Restriction of the Health Information to be Used or Disclosed. The following is a description of the specific health information I wish to restrict:

Persons/Organizations Restricted from Use and/or Disclose Health Information. I request that the following person(s) and/or organization(s), not be allowed to use and/or disclose the health information described above.

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____/_____/_____
Signature Date

If signed by personal representative:
Name of Personal Representative:

Relationship to Patient:

_____ _____/_____/_____
Signature of Personal Representative Date