

The purpose of this form is to document specific instances where disclosure of protected health information has been requested to be restricted by the individual.

Date: \_\_\_\_\_

**Information on Person Requesting Restriction**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medical Record/Set: \_\_\_\_\_

Reason for Restriction: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe what information you wish to restrict from disclosure: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Access should be denied to the following individual(s):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

We have the right to revoke this restriction at any time. The termination of the restriction will only be effective for protected health information received or created after we inform you that the restriction has been revoked.

\_\_\_\_\_  
*Signature of Patient or Legal Patient Representative*

\_\_\_\_\_  
*Date*