Limit What We Use or Share

Request to restrict use and disclosure of my medical records

Patient Name _____ Birthdate _____

I am asking to limit the following information from being used and disclosed (be specific):

_____

_____

_____

The clinic will carefully consider all requests, but is not required to agree to a requested restriction.

Signature of Patient _____ Date _____
(or Parent/Guardian)

Internal Use Only

Clinic Name _____ Date _____

Received By _____ Date _____

Privacy Officer Reviewed _____ Date _____

Clinician Reviewed _____ Date _____

Comments _____

_____

_____

_____

