

Restriction of Use and Disclosures Request (04/14/03)

Implemented 04/14/03

Name: _____ DOB / ID #: _____

Address: _____ Phone #: _____

Record Holder: _____ Date of Request: ____ / ____ / ____

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

I understand that the City will consider my request but is not required to agree to my request for restricting use or disclosure of my health information.

Signature of the Patient/Client or Legal Representative

Date

Approved

Denied

Comments: _____

Staff Signature: _____ Date: ____ / ____ / ____