Patient Name:
MRN:
DOB:

100118

Request for Restriction on Uses & Disclosures of Protected Health Information

Please complete the following information: **Date:** _____

1. **Date(s) of Encounter to be held as Restricted:** _____
2. **Type of Encounter(s) to be held as Restricted:** _____
3. **Listing of Ancillary Service(s) to be held as Restricted:** _____
4. **From whom should this information be restricted:** _____

	List Specific Tests/Encounters	List the Date of the Tests
Clinical (Lab) Test:	_____	_____
Medical Imaging (x-ray)Test	_____	_____
Behavioral Health Reports	_____	_____
Therapy reports	_____	_____
Other	_____	_____

5. **Name of the Healthcare Provider(s) who was seen at the time of the Encounter:**
   _____ _____
   _____

Patient Name:
MRN:
DOB:

Request for Restriction on Uses & Disclosures of Protected Health Information

Restriction has been: **Accepted** **Denied (If denied, check the reason for denial):**

Upon recommendation of the Health care Provider

Upon recommendation of the Operational Review Team

Federal/State law prohibits the restriction