Requested Restriction on the Uses and Disclosures of PHI for Treatment, Payment or Operations

Name: _____

Number: _____
(if applicable)

Social Security Number: _____

Address: _____

_____

Telephone Number: _____

Restriction requested: _____

_____

_____

_____

Signature of individual (required): _____

This restriction reviewed with above-named individual on: _____
Date

Signed: _____

Print Name and Position:

Face to Face: _____ Phone call: _____

Restriction Approved: Yes _
No _

Date: _____

Signature of employee approving/denying restriction: _____

Name of employee approving/denying restriction: _____

Signature of Privacy Official: _____

Date: _____