Request for Restrictions on Use and Disclosures of Health Information

Member Name:_____ Date of Birth:_____
Medical Record #:_____
Member Address:_____

_____

Number where you can be reached:_____

I understand that I may request restrictions on specified uses and disclosures of my health information. I further understand that there are certain uses and disclosures of health information that are required or permitted by state and/or federal law for which I cannot request restrictions. I have been informed that this agency is not required to honor my request for restrictions on the use and disclosure of my health information.

I hereby request restriction of the following use and disclosure of my health information that is created or maintained by this agency in the following circumstances:_____

_____

_____

_____

Reason for this request: _____

_____

_____

_____

_____ _____ _____
Member/Legally Responsible Person Relationship Date

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This Section for Agency Use Only

❑ **Request APPROVED**

Agency Requirements:
- ❑ Notification to staff of restrictions
- ❑ Notification to Business Associates, as needed

❑ **Request DENIED**

Reason for Denial:
- ❑ Too expensive to accommodate request
- ❑ Administratively impractical to accommodate request
- ❑ May prevent effective treatment
- ❑ Other:_____

_____ _____ _____
Alliance Staff Signature Title Date

Once completed, scan and save form per procedure.