



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

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
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Once completed, scan and save form per procedure.