Use this form during patient registration to document any patient requests to authorize and restrict how their health information is disclosed to friends/family members/others. Use also to document any requests for confidential communications.

Patient Authorization for General Disclosure and/or Request for Restrictions of Protected Health Information and Request for Confidential Communications

I hereby request the following use or disclosure of my health information as described below.

Patient Name	Date of Birth	Medical Record Number

Address (Street, City, State, ZIP Code)	Telephone Number

I request that my health information or medical billing record be disclosed or restricted, as follows:

I authorize the names listed below to have access to my medical Information. These people may call and speak with the nurse/doctor about my case. I have the right to terminate this agreement at any time by informing a representative of the physician office.

Authorized Name	**Relationship to Patient**

*__DO NOT__ discuss or provide information to the following individuals or entities:

Restricted Name/Entity	**Relationship to Patient**

*I request the use of **ONLY** the following address and/or phone number(s) to contact me regarding my health or billing information:

_____

_____

_____

Patient Rights: Your physician office must permit patients to request restrictions of their protected health information. Patients may request restriction of uses and disclosures of protected health information to carry out treatment, payment, and healthcare operations; disclosures to a family member, other relative, close personal friend, or any other person identified by the patient of protected health information directly relevant to such person's involvement with the patient's care; and disclosures of protected health information to notify or assist in the notification of a family member, a personal representative, or another person responsible for the care of the patient of the patient's location, general condition, or death. All requests for restrictions must be submitted in writing.

Physician Office Responsibilities: Your physician office is not required to grant most restrictions and is precluded from granting restrictions that would violate the law. If we agree to the restriction, we will comply with it unless you ask to terminate the restriction or we notify you that we are terminating the agreement. If you require emergency treatment, we may release the restricted information without your consent if it is needed to provide that treatment.

Signature of Patient or Legal Representative	Date

If Signed by Legal Representative, Relationship to Patient

_____

THIS SECTION TO BE COMPLETED BY PHYSICIAN OFFICE PERSONNEL ONLY

DISPOSITION of PATIENT REQUEST: The above request for restriction of health information by the above-named patient has been:

*Granted _____ Denied _____

*If GRANTED, an Alert must be entered into all electronic medical records and/or practice management (billing) system(s).

Reason(s) for Denial, if Applicable _____

_____

_____

Physician Office Representative: Date: