



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:

_____ **9**

