



EMRN:

HCL:

Request for Restrictions of Protected Health Information

Federal law permits you to request that we place limits on our disclosure or use of your protected health information. **[45 C.F.P. §164.506] We are not required to agree to your request; in some cases it may be impossible or impractical for us to implement it.** However, we will try to accommodate all reasonable patient requests. We are also required by law to keep records of your requests and if we do agree to it, we are bound by that agreement and required to honor it.

Print Patient Name: _____	Date of Birth: _____
Address: _____	
Home Number: _____	Other Number: _____

PROHIBIT SPECIFIC DISCLOSURES: I request that you do not disclose the specific protected health information to the individuals listed below:

I do not want any my protective health Information disclosed to the following party(s):

Name:	Relationship	Phone Number #
1. _____		
2. _____		
3. _____		

Patient Signature: _____ **Date:** _____
(Patient or Legal Representative)

For Facey office use only

- Facey Medical Group has **AGREED** to your request for a restriction and will be bound by it.
- Facey Medical Group is **UNABLE TO AGREE** to your request for a restriction. We are not required to restrict any information to your Health plan for the purposes of carrying out treatment, payment or health care operations.

Facey Medical Group
Officiate Confirming Signature: _____ **Date:** _____

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose protected health information about you. A copy is available at any of our Facey Medical Group Locations. [45 C.F.P. §164.506] Or at www.facey.com