



REQUEST FOR RESTRICTION OF HEALTH INFORMATION
PATIENT OR LEGAL REPRESENTATIVE MUST COMPLETE ITEMS 1 - 13

1. Today's Date _____

2. Patient's Name _____

3. Patient's Date of Birth _____

4. Patient's Medical Record Number (if known) _____

5. Patient's Social Security Number _____

6. Describe the information you are requesting to restrict: _____

7. Date(s) of the information you are requesting to restrict: _____

8. What is the reason for this request? _____

9. Is the information you are requesting to restrict (select all that apply):

- INCORRECT**
- INCOMPLETE**
- OUTDATED?**
- OTHER** _____

10. Signature of Patient's Legal Representative _____

11. Date _____

12. Printed Name of Patient's Legal Representative _____

13. Relationship to Patient _____

DO NOT WRITE BELOW THIS LINE

HEALTHCARE ORGANIZATION MUST COMPLETE ALL ITEMS BELOW

The restriction has been: **Accepted** **Denied**

If denied, indicate reason for denial: _____

Signature of Authorized Individual _____

Date _____

Printed Name of Authorized Individual _____