Arthritis and Rheumatism Associates, P.C.

REQUEST TO RESTRICT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Medical Record (Internal Use):_____

Health Information Restriction: I request that the disclosure of my information maintained in my medical record be restricted in the following manner (if none of these apply then skip down to Other Restrictions):

_____Do not disclose this visit (cash pay only)

_____Do not disclose my name

_____Do not disclose my general condition to:_____

Other Restrictions: I request the following restriction(s) on the use or disclosure of my Protected Health Information:

_____Do not release information to the following person(s):_____

_____

Other restriction(s): You may include attachments if this does not provide you enough space. Please sign this document.

_____

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Signature of Patient or Personal Representative: _____

Date: _____

Print Name: _____