Physicians Independent Management Services, Inc.
Request for Restriction(s)

Patient Name: Date of Birth: Patient Record #

Address City State Zip Code

I understand that I have the right to request restriction(s) as to how my protected health information may be used and/or disclosed to carry out treatment, payment or health care operations, or disclosed to family members and others involved in my care. I understand your practice may not be required to agree to the restriction(s) requested. Even if my request for restriction is denied, I will generally have an opportunity to agree or object prior to disclosures to persons involved in my care. If the practice agrees to a requested restriction, it will be binding except in the case of emergency treatment. If restricted information is released for my emergency treatment, practice will request the provider not to further use and/or disclose that information.

I request the following restriction(s) on the use and/or disclosure of my protected health information:

Signature of Patient or Personal Representative Date

For Office Use Only

Date Received ☐ Request is approved. ☐ Request is denied.

If denied, reason for denial must be listed.

Reason for denial

Comments

Date:

Signature of responsible party reviewing this request