Carolina Pines ENT	*Protected Health Information Restriction Request Form*	**Revision Number: 001**

Date Received	
Initials of HIPAA Compliance Officer	

Patient to complete the following information:

Patient Name: _____

Date: _____

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 (please specify):

  _____

  _____

  _____

Signature of Patient or Personal Representative	
Patient Name	
Name of Personal Representative (if applicable)	
Date	

Protected Health Information Restriction Request Form

Facility to complete the following

FACILITY RESPONSE

- ☐Your request for restriction has been declined.
- ☐Your request for restriction has been accepted. In the case of an emergency or if necessary to comply with the law, we may use and disclose your health information in violation of the restriction. Other than in those circumstances, we will abide by your request unless and until the restriction is terminated (with or without your agreement) and you are notified.

Completed by	
Signature of Facility Representative	
Date	

TERMINATION OF RESTRICTION

- ☐The above name patient agreed to terminate this restriction on _____

- ☐The above-named patient was notified on _____ (date) that this restriction was terminated.
    - Patient was notified: (check appropriate box):
    - ☐In person
    - ☐By telephone (attach documentation of notification)
    - ☐By mail (attach documentation of notification)

Completed by	
Signature of Facility Representative	
Date	