RESTRICTION REQUEST FORM

For Use and Disclosure of Patient Health Information

In completing this form, you are requesting that the following restrictions be considered as limitations to the use and disclosure of your protected health information. If we grant your request, we are bound by the terms of the agreement. You will be notified in writing of Weil Foot and Ankle Institutes decision to accept or deny your restriction request. Until a decision is reached, your request for restriction will not be honored.

Requested Restrictions (please provide specific details and dates):

_____

_____

_____

Print Patient Name: _____

Signature of Patient or Authorized Representative: _____

Date: _____

Relationship to Patient: _____

For Practice Use Only:

Practice: ☐ Accepts ☐ Denies

Privacy Officer Signature: _____

Date: _____