Generations Family Practice

REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF HEALTH INFORMATION

I, the undersigned, do hereby request Generations Family Practice to restrict the use or release of health information concerning _____, DOB _____, for the time period of _____ to _____ as follows:

1. Name and address of person or entity to whom I do not want health information disclosed:_____

_____.

Description of health information I do not want disclosed to this person or entity:

_____

_____

_____

2. Name and address of person or entity to whom I do not want health information disclosed:_____

_____.

Description of health information I do not want disclosed to this person or entity:

_____

_____

_____

3. Name and address of person or entity to whom I do not want health information disclosed:_____

_____.

Description of health information I do not want disclosed to this person or entity:

_____

_____

_____

I understand that Generations Family Practice is not required to agree to any of my requests, except for requests that my health information not be provided to any third party payor for payment or operations purposes where I have already paid for the costs associated with my care and treatment out of pocket in full. For all other requests for restriction, if Generations Family Practice does agree it will comply with my requested restriction(s) unless the information is needed to provide me emergency treatment. Generations Family Practice and I each have the right to end the restriction at any time upon written notice to the other; however, Generations Family Practice will not be permitted to disclose to a third party payor any health information about care or treatment, the costs for which I have already paid for in full and out of pocket (without resort to my third party payor).

_____ _____

Signature of Patient or Authorized Party Date

_____ _____

Relationship to Patient Printed Name