Request for Restriction on Use/Disclosure of Protected Health Information (PHI)

Client Information:
Name: _____
Date of Birth: _____

Requested Restriction (check all that apply):
☐ Medical Records
☐ Treatment Plans
☐ Billing Information
☐ Other:
_____
_____

Description of Restriction (include specific purposes or individuals/entities to restrict):

Acknowledgment by Covered Entity:
☐ Approved
☐ Denied
Reason (if denied):
_____
_____

Client/Legal Representative Signature
Signature: _____
Date: _____

Legal Representative Information (if applicable):
Name: _____
Relationship to Client: _____

Covered Entity Representative
Name: _____
Signature: _____
Date: _____