PATIENT REQUEST FOR RESTRICTION(S) OF HEALTH INFORMATION

Patient Name: ____ Date of Birth: _______________

Patient Address: ____

Patient Telephone Number: ____

Restricted from whom (please be as specific as possible): ____________________________

____

____

____

I understand that I have the right to request a restriction(s) as to how my protected health information may be used and/or disclosed to carry out treatment, payment or health care operations. I understand that TGH is not required to agree to the requested restriction(s) except if I want to restrict information to my insurance carrier and I (or someone on my behalf) pays in full for the service provided. I understand that TGH will notify me of the decision in writing. Any restrictions that are approved will be honored until either TGH or I (or my representative) revoke the request.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(If Personal Representative, state relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

Patient Request for Restriction(s)
of Health Information

Patient Information