montgomery medical associates, pc

Request for Restriction(s) Form

Patient Rights: As a patient, you have the right to request restrictions to the uses and disclosures of your Protected Health Information (PHI). You have the right to request restriction(s) as to how your protected health information may be used and/or disclosed to carry out treatment, payment or health care operations, or disclosed to family members and others involved in your care.

PATIENT IDENTIFICATION:

Name *(Last, First, MI):* ..... Birth Date: .....

Mailing Address: .....

City & State: ..... Zip Code: .....

Power of Attorney Name and Contact: .....

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Please indicate your request for restricted uses or disclosures of your PHI:

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I understand that MMA may not be required to agree to the restriction(s) requested. Even if my request for restriction is denied, I will generally have an opportunity to agree or object prior to disclosures to persons involved in my care. If MMA agrees to a requested restriction, it will be binding except in the case of emergency treatment. If restricted information is released for my emergency treatment, MMA will request the provider not to further use and/or disclose that information.

Signature of Patient: ..... Date: .....

If Personal Representative, state relationship to patient: .....

☐ Accepted *(If accepted, state which of the restriction(s) accepted):*

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☐ Denied *(If denied, state the reason of denial):*

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Physician Signature: ..... Date: .....