**CNMRI, PA**
**Form to Request Restrictions**
**on Use and Disclosure of Protected Health Information**

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. ***We are not required to agree to this restriction, but if we do, we are bound by our agreement. Any restriction we accept will not apply when the restricted information is needed to provide you with emergency treatment. We further have the right to terminate any agreed upon restriction by informing you of the termination in writing. Any such termination will only apply to information created or received after we have informed you of the termination.***

Please complete this form to request a restriction and we will notify you of our ability to comply with your request by returning a copy of this form to you, no later than 30 days from its receipt. You also have the right to request us to terminate a restriction to the extent that such termination applies to information created or received after the date of termination.

I, _____( PRINT INDIVIDUAL'S NAME ), am requesting that the office of _____( PRINT PROVIDER'S NAME ) restrict use or disclosure of my protected health information in the following manner:

DATE TERMINATED

- ❑ Register me anonymously under the alias:_____ _____
- ❑ Do not release information specified below to:_____ _____

  *Information*:_____

- ❑ Send information specified below by the following alternative means or to the following alternative address:_____ _____

  *Information*:_____

  Do not send communications concerning ☐ appointment reminders, ☐ marketing, or ☐ fundraising to me.

  If this restriction applies to information to be sent to my insurance company, I will guarantee payment of my healthcare services by:

  - ❑ Advance payment of $_____
  - ❑ Credit assurance in the form of Card No._____ Expiration Date:___/___
  - ❑ Other financial agreement:_____
- ❑ Other:_____ _____

SIGNATURE OF INDIVIDUAL OR
PERSONAL REPRESENTATIVE: _____ ___

DATE:_____

ADDRESS: _____

PRINT PERSONAL REPRESENTATIVE
NAME: _____

RELATIONSHIP TO PATIENT: _____

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I HEREBY REQUEST RESTRICTION(S) MARKED ABOVE BY DATE OF TERMINATION TO BE TERMINATED:

SIGNATURE OF INDIVIDUAL OR
PERSONAL REPRESENTATIVE: _____

DATE: _____

FOR OFFICE USE ONLY

- ❑ We have accepted the restriction(s) you have requested above. Any exceptions are listed below:
- ❑ We are unable to accept the following restriction you have requested:

_____

- ❑ By this form being sent to you, we are informing you that the above restrictions are being terminated.

SIGNATURE OF LICENSED
HEALTHCARE PROFESSIONAL: _____
DATE: _____