PURPOSE:

Patients form for requesting restriction to protected health information.

INDIVIDUAL RESPONSIBLE FOR COMPLETING:

Person requesting restriction to protected health information.

WHEN FORM IS TO BE COMPLETED:

At the time of the request to restrict protected health information.

INSTRUCTIONS FOR COMPLETING:

The patient will complete and sign the form.

ROUTING:

Completed forms will be directed to the HIPAA Privacy Officer.

RETENTION:

The form will be retained with the PPCR.

COPIES TO:

No additional copies required.

TOWN OF CHILHOWIE FIRE DEPARTMENT

PATIENT REQUEST FOR RESTRICTION FORM

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security #: _____

Patient Rights: As a patient, you have the right to access, copy or inspect your PHI, amend your PHI, request an accounting of the uses and disclosures of PHI for the last six (6) years, prior to the date of the request, from the Town of Chilhowie Fire Department, to amend your PHI and to request restrictions to the uses and disclosures of your PHI. The Town of Chilhowie Fire Department is not required to agree to any restrictions requested by the patient; however any restrictions agreed to by the Town of Chilhowie Fire Department are binding on the Town of Chilhowie Fire Department.

Please indicate your request for restricted uses and disclosures of your PHI below:

_____

_____

_____

_____

_____

_____

Signature _____ *Date* _____