GOLD COAST MEDICAL

Personal Health Information Disclosure Restriction Request

The purpose of this form is to document specific instances where disclosure of protected health information has been requested to be restricted by the individual.

Date: _____

Information on Person Requesting Restriction

Patient Name:_____ Date of Birth: _____

Medical Record/Set: _____

Reason for Restriction:_____

_____

_____

_____

_____

Please describe what information you wish to restrict from disclosure: _____

_____

_____

_____

_____

_____

Access should be denied to the following individual(s):

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship: _____

We have the right to revoke this restriction at any time. The termination of the restriction will only be effective for protected health information received or created after we inform you that the restriction has been revoked.

_____ _____

Signature of Patient or Legal Patient Representative *Date*