PLUMAS COUNTY, CALIFORNIA

REQUEST FOR SPECIAL RESTRICTION ON USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this form provides to _____ the patient's wishes in regard to the use and disclosure of protected health information, as set forth below, consistent with California and federal laws concerning the privacy of such information.

_____ does not have to agree to the patient's request and if it does, it may share the information in certain circumstances described by law.

Date:_____

Patient Name:_____

Date of Birth:_____

I hereby request a restriction on _____'s use or disclosure of protected health information. The information I want limited is:

_____

_____

_____

I want to limit:

☐ Use of this information.

☐ Disclosure of this information.

☐ Both the use and disclosure of this information.

I want the limits to apply to the following person / entity: _____

If this special restriction is agreed to, it may be terminated if:

1. I request or agree to the termination in writing.
2. I orally agree to the termination and the oral agreement is documented.
3. _____ informs me that it is terminating the agreement. In this case, the termination is only effective for protected health information created or received by _____ after I am notified of the termination.

_____ _____

Signature of individual or representative Date

If representative, give relationship:_____