ACUPUNCTURE
WELLNESS CENTER LLC
EAT WELL - LIVE WELL - BE WELL

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Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communication Form

Client Identification:

Client Name:_____ Date of Birth:_____ Client ID #:_____
Client Address:_____
Street Apt # City State Zip
Home Phone:(_____)_____ Work Phone : (_____)_____ Cell Phone : (_____)_____

Request for Restriction:

1. Medical Information to be Restricted: _____
_____
2. Nature of Restriction: _____
_____
3. Medical Information to be Communicated Confidentially: _____
_____
4. Alternative Location/Address/Telephone Number/E-mail: _____
_____

TO OUR PATIENTS: You have the right to request that Acupuncture Wellness Center, LLC restricts our use and disclosure of your medical records and information. We do not have to agree to your requested restrictions. Generally, we will not agree to requests to limit disclosure of your information related to (a) the coordination of your medical care, (b) the internal operations of our practice, or (c) legal requirements. It is simply too difficult to comply with such restrictions.
You also have the right to request that we communicate certain medical information to you or someone you have allowed to receive your information in confidence. We will accommodate your reasonable written requests to receive communications of medical information by alternative means, at alterative locations and/or to allow someone you have designated to receive confidential information only if you (a) specify the person you have allowed access to your confidential information, (b) specify the alternative location, address, telephone number or fax number and/or the alternative means of contact, and (c) agree to be responsible for and explain how payment will be handled for any additional costs associated with the alternative method of communication.

By your signature below, you acknowledge that you understand and agree to the above information.

_____ _____ _____
Name (Printed) Signature Date
If Personal Representative, please provide proof of identity and/or describe authority: _____

This section is for agency use only

- ❑ Request for **Restriction ACCEPTED**
- ❑ Request for **Restriction DENIED**
  - Reason for Denial:
    - ❑ Administratively impractical to accommodate request
    - ❑ Failure of Client to specify an alternative accommodation
    - ❑ Too expensive to accommodate request
- ❑ Request to **Communicate Confidentiality ACCEPTED**
- ❑ Request to **Communicate Confidentiality DENIED**

by: _____ _____ _____
Staff Signature Title Date

This Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communication Form is to be made a part of the medical record of:

_____ _____ _____
Patient's Name (Printed) Patient's Signature Date