

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 alternative 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

<input type="checkbox"/> Request for Restriction ACCEPTED <input type="checkbox"/> Request for Restriction DENIED Reason for Denial: <div style="display: inline-block; vertical-align: top; margin-left: 20px;"> <input type="checkbox"/> Administratively impractical to accommodate request <input type="checkbox"/> Failure of Client to specify an alternative accommodation <input type="checkbox"/> Too expensive to accommodate request </div>	<input type="checkbox"/> Request to Communicate Confidentiality ACCEPTED <input type="checkbox"/> 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 _____
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