**Client/Patient Information:**

Name of Client/Patient Date of Birth (mm/dd/yyyy) Phone Number

Address City, State, Zip

**CLIENT/PATIENT RESTRICTION REQUEST**

I am requesting a restriction of disclosure of the following Protected Health Information (PHI):

Please identify all visits or encounters that were fully paid out of pocket:

I understand that this request may be denied as authorized by law. I further understand that this request may not be honored in emergency situations.

Signature: Date:

If this form is completed by a parent/guardian/authorized agent on behalf of the client/patient, complete the following:

Parent/Guardian/Authorized Agent’s Name (please print)

Please check one of the following:

[ ]  Parent/Guardian

[ ]  Authorized Agent

|  |
| --- |
| For Office Use Only If Records Requested to be Inspected:Name of Inspecting Person:       Records Released for Inspection:        |