FACEY MEDICAL GROUP
An affiliate of PROVIDENCE Health & Services

Request for Restrictions of Protected Health Information

Federal law permits you to request that we place limits on our disclosure or use of your protected health information. ***[45 C.F.P. §164.506] We are not required to agree to your request; in some cases it may be impossible or impractical for us to implement it.*** However, we will try to accommodate all reasonable patient requests. We are also required by law to keep records of your requests and if we do agree to it, we are bound by that agreement and required to honor it.

Print Patient Name:_____ EMRN#_____

Address: _____ Date of Birth: _____

Home Number: _____ Other Number:_____

PROHIBIT SPECIFIC DISCLOSURES: I request that you do not disclose the specific protected health information to the people listed below:

I do not want any my protective health Information disclosed to the following party(s):

	Name:	**Relationship**	**Phone Number #**
1.			
2.			
3.			

Patient Signature: _____ Date: _____
(Patient or Legal Representative)

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose protected health information about you. A copy is available at any of our Facey Medical Group Locations. [45 C.F.P. §164.506] Or at www.facey.com

For Facey office use only

☐ **Facey Medical Group** has **AGREED** to your request for a restriction and will be bound by it.

☐ **Facey Medical Group is UNABLE TO AGREE** to your request for a restriction. We are not required to restrict any information to your Health plan for the purposes of carrying out treatment, payment or health care operations**.**

Facey Medical Group
Officiate Confirming Signature: _____Date: _____

Patient Name	Medical Record#
Patient Date of Birth	Patient Telephone #
Dr. Name	Dr. # Loc:
Appointment Date	
Insurance Coverage	
Insurance Benefits - Co – Pay	