

**REQUEST FOR RESTRICTION OF HEALTH INFORMATION**  
**PATIENT OR LEGAL REPRESENTATIVE MUST COMPLETE ITEMS 1 - 13**

1. Today's Date \_\_\_\_\_

2. Patient's Name \_\_\_\_\_

3. Patient's Date of Birth \_\_\_\_\_

4. Patient's Medical Record Number (if known) \_\_\_\_\_

5. Patient's Social Security Number \_\_\_\_\_

6. Describe the information you are requesting to restrict: \_\_\_\_\_  
\_\_\_\_\_

7. Date(s) of the information you are requesting to restrict: \_\_\_\_\_

8. What is the reason for this request? \_\_\_\_\_  
\_\_\_\_\_

9. Is the information you are requesting to restrict (select all that apply):

- INCORRECT**
- INCOMPLETE**
- OUTDATED?**
- OTHER** \_\_\_\_\_

10. Signature of Patient or Legal Representative \_\_\_\_\_

11. Date \_\_\_\_\_

12. Printed Name of Patient's Legal Representative \_\_\_\_\_

13. Relationship to Patient \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

**HEALTHCARE ORGANIZATION MUST COMPLETE ALL ITEMS BELOW**

The restriction has been:  **Accepted**     **Denied**

If denied, indicate reason for denial: \_\_\_\_\_  
\_\_\_\_\_

Signature of Authorized Individual \_\_\_\_\_

Date \_\_\_\_\_

Printed Name of Authorized Individual \_\_\_\_\_