Washington Health Medical Group

REQUEST FOR RESTRICTION ON USES AND DISCLOSURES OF HEALTH INFORMATION BY WASHINGTON HEALTH MEDICAL GROUP

Patient Name: _____ Date of Request: _____

Patient Date of Birth:_____

□ I give permission for Washington Township Medical Foundation to disclose my health information to the following family members, friends or other people involved in my care:

Name: Relationship:

a. _____

b. _____

c. _____

d. _____

e. _____

You have the right to ask us to restrict or disclose medical information we make to those family members or others involved in your care or involved in payment for your care or for notification purposes. We are not required to agree to your request. If we do agree, we will put it in writing and will abide by the agreement except when you require emergency treatment. If we do not agree to your request, we will notify you of our decision in writing.

By submitting this form, I hereby request that Washington Health Medical Group disclose of patient health information as described above. I understand and acknowledge that the clinic is not required to agree to this request.

Print name of Patient or Representative: _____

Signature of Patient or Representative: _____

FOR MEDICAL STAFF USE ONLY

Date form received: _____ **Staff initials:** _____

□ I am withdrawing my permission to disclose my health information to the following family members, friends or other people involved in my care:

a. _____ b. _____

c. _____ d. _____

e. _____

Print name of Patient or Representative: _____ Date: _____

Signature of Patient or Representative: _____

FOR MEDICAL STAFF USE ONLY

Date form received: _____ **Staff initials:** _____