INTERNAL MEDICINE DIAGNOSTICS

197 HOSPITAL DR., SUITE B
CHEROKEE VLG, AR 72529
PHONE: 870-257-5118
PRIVACY OFFICIAL: NIRMAL SIDHU

Request to Restrict Uses and Disclosures of Protected Health Information

Notice to Patient: You may use this form to request that our Practice agree to additional restrictions on the uses and disclosures of protected health information about you. We call this a "Further Restriction Request." You may make such a request regarding uses and disclosures for treatment, payment, or health care operations, and uses and disclosures to family and friends involved in your care or payment for your care. The HIPAA Privacy Rule permits you to make a request, but it does not require us to agree to your request. This is described in our Practice's Notice of Privacy Practices.

To assist our Practice in responding promptly and accurately to your Further Restriction Request, please complete this form in its entirety.

Patient Name: _____

Requested Restriction
Please describe in detail how you would like for our Practice to further restrict the use and disclosure of protected health information about you.

_____
_____
_____
_____

Reason for Further Restriction Request
Please specify the reason(s) for your Further Restriction Request.

_____
_____
_____
_____

Contact Person
Please contact our Practice's Privacy Official, listed above, if you have any questions relating to your Further Restriction Request.

Patient Information

Print Name of Patient: _____
Signature of Patient: _____
Date: _____
Date of Birth: _____

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative (PR): _____
Describe PR Relationship (parent, guardian, power of attorney, etc): _____

I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.

Signature of Personal Representative: _____
Date: _____