Request For Restriction On Use and Disclosure of Medical Information and/or Confidential Communication

melmed center™

Date:_____Patient Name: _____

Phone Number (Day):_____Phone Number (Evening): _____

Address or PO Box: _____

City: _____ State:_____Zip: _____

1) Medical Information to be Restricted from:

2) Medical Information to be Restricted:

3) Medical Information to be Communicated Confidentially:

4) Alternative Location/Address/Telephone Number:

TO OUR PATIENTS: You have the right to request that we restrict our use and disclosure of your medical records and information. We do not have to agree to your requested restrictions. If we do agree to the requested restriction, we will abide by the restriction unless a medical emergency requires otherwise. You also have the right to request that we communicate certain medical information to you in confidence. We will accommodate your reasonable written requests to receive communications of medical information by alternative means or at alternative locations only if you (1) specify the alternative location, address, and/or telephone number and (2) agree to be responsible for and explain how payment will be handled for any additional costs associated with the alternative method of communication. This request will be part of the medical record.

By your signature below, you acknowledge that you understand and agree to the above information.

Signature of Patient/Parent/Legal Guardian:_____

For Official Use Only
Request for Restriction: Accepted_____Denied_____
Request to Communicate Confidentiality: Accepted_____Denied_____
Officer's Initials:_____Today's Date:_____