

**FORM TO REQUEST RESTRICTIONS ON COMMUNICATION
AND/OR DISCLOSURE
OF MY PERSONAL HEALTHCARE INFORMATION
TO FAMILY, FRIENDS AND OTHERS**

I request the following restrictions to the use or disclosure of my personally identifiable health information:

Printed Name (Client)

Signature of client or his or her personal representative

Date

Printed name of client or personal representative

Relationship to client

Description of Personal Representative's Authority

Accepted Rejected

Reason(s):

Printed Name of Privacy Officer

Signature

Date