

Form 20: Patient Request for Restriction

Hebron Fire Department
Patient Request for Restriction Form

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security No.: _____

Patient Rights: As a patient, you have the right to request restrictions to the uses and disclosures of your PHI. **Hebron Fire Department is not required to agree to any restrictions requested by the patient; however, any restrictions agreed to by Hebron Fire Department are binding on Hebron Fire Department.**

Please indicate your request for restricted uses and disclosures of your PHI.

Signature _____ *Date* _____

FOR AMBULANCE SERVICE USE ONLY:

DATE REC'D _____

REQUEST ACCEPTED _____

REQUEST DENIED _____

DATE _____

REVIEWING OFFICIAL _____

NOTICE TO PATIENT _____

COMMENTS: