HENRY COUNTY HEALTH DEPARTMENT

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Request for Restrictions on Use/Disclosure of PHI

Patient Name: _____ Birth Date: _____

I, _____ am requesting a restriction on Henry County General Health District use and/or disclosure of my health information in the manner described below. I understand that Henry County General Health District may deny this request. I also understand that if agreed to, Henry County General Health District may not be able to honor this request if I require emergency treatment.

Description of Restriction of the Health Information to be Used or Disclosed. The following is a description of the specific health information I wish to restrict:

_____

_____

_____

Persons/Organizations Restricted from Use and/or Disclose Health Information. I request that the following person(s) and/or organization(s), not be allowed to use and/or disclose the health information described above.

_____

_____

_____

By signing here, I am confirming that the above request for restriction from use and /or disclosure of PHI accurately reflects my wishes.

_____ _____

Patient Signature (Guardian or Health Care Power of Attorney) Date

Henry County Health Department Response

_____

_____

_____

Termination of restriction, if applicable

By signing here, I am confirming that it accurately reflects my wishes to terminate the request for restrictions from use and /or disclosure of PHI that was previously requested.

_____ _____

Patient Signature (Guardian or Health Care Power of Attorney) Date

HCHD Original: 4/03, 11/2017, 9/2018