Restriction of Use or Disclosure of Protected Health Information (PHI) Form

I, ____, request that Revolution Health & Wellness Clinic, PLLC **restrict the use or disclosure of my health information for payment or health care operations in the manner described here: (Please be specific)**

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I understand that Revolution Health & Wellness is not required by law to accept my requested restrictions, but if the practice does, Revolution Health & Wellness agrees to abide by the restrictions except in emergency situations.

I understand that either I or Revolution Health & wellness may terminate this restriction in writing at any time in the future.

Patient Signature: ____
Printed Name and date of birth:___________________________________
Date: ____

Privacy Officer Comments:

___ Accept this request.

___ Reject this request. Reason:____

___ Patient contacted.