REQUEST FOR RESTRICTIONS ON
USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ____ Birth Date: _______/_______/______
MM / DD / YR

Address: ____

____

Home Telephone Number: __________________________ E-mail: ________________________________

Patient Identification Number and/or Social Security Number: _____________ ______________________

I, ____ am requesting a restriction on Koru Medical's use and/or disclosure of my health information in the manner described below. I understand that Koru Medical may deny this request. I also understand that if agreed to, Koru Medical 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.

____

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By signing this form, I am confirming that it accurately reflects my wishes.

____ _______/_______/_______
Signature Date

If signed by personal representative:
Printed Name of Personal Representative: ____

Relationship to Patient: ____

____ _______/_______/________
Signature of Personal Representative Date

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