Connecticut Neck & Back Specialists, LLC

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Request for Restrictions on Uses and Disclosures of Protected Health Information

PATIENT INFORMATION:

Patient Name: _____ Patient Date of Birth: _____

Patient Address: _____

Patient Phone: _____ Patient email: _____

I hereby request that this practice restrict:

☐ Uses and disclosures of my protected health information to carry out treatment, payment or healthcare operations as follows (please specify):

_____

_____

☐ Disclosures to family and friends involved in my care or for notification purposes as follows (please specify):

_____

_____

I understand that this practice is not required to agree to my request for restrictions and that disclosures required by law and for emergency treatment shall be made regardless of any request for restrictions made by me.

Authorized & Accepted By (Privacy Officer or Designee):

_____ _____

Signature of Patient | On behalf of Connecticut Neck & Back Specialists

_____ _____

Date | Date

☐ Check when notation has been made in patient's record