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**RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES & DISCLOSURES
OF PROTECTED HEALTH INFORMATION**

Name of Patient: _____ Date of Birth: _____

I understand that my health care provider may use or disclose my protected health information ("PHI") for the purposes of treatment, payment, and health care operations, but that I can request restrictions on the PHI that is used or disclosed. I am requesting a restriction on the use/disclosure of my PHI in the manner described below. I understand that my health care provider may deny this request for any reason. If my request is approved, I understand that the restriction will not apply in case of an emergency.

I also understand that, if my request for a restriction is approved, my health care provider may terminate this restriction if I agree to or request such termination in writing. I also understand that my health care provider may terminate the restriction that we agreed to if my provider informs me of his or her decision to terminate the restriction. However, such termination affects only information created or received by him or her after such termination.

Description of the Specific Health Information to be Restricted: _____

Persons/Organization Restricted From Receiving My PHI:

Signature of Patient: _____ Date: _____

Name of Personal Representative (if necessary): _____

Signature of Personal Representative: _____ Date: _____

Relationship to Patient: _____

For Provider Use Only

Request is Approved: _____

Request is Denied: _____

Signature of Privacy Officer: _____