Request for Restriction on Disclosures

I am requesting a restriction on disclosures of my health information for purposes other than treatment, payment for care, or administrative activities.

Patient Name: _____

Date of Birth: _____ Phone Number: _____

Postal Address: _____

Email Address: _____

Period of Accounting of Disclosures:

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Start Date: January 17, 2018 or Later Date: _____

End Date: _____

_____ _____

Signature of patient or personal representative Date

If signer is a patient representative, please describe your relationship to the patient and your authority to act on his/her behalf:

If patient is a minor:
- ☐ Parent
- ☐ Legal Guardian
- ☐ Self

If patient is an adult:
- ☐ Court-appointed guardian
- ☐ Durable medical power of attorney to authorize disclosure of health information on behalf of the patient (attach form and highlight relevant permission)
- ☐ Health care proxy (attach form and highlight relevant permission)
- ☐ Administrator or executor of the deceased patient's estate (attach death certificate and surrogate's documentation)

Restrictions: _____

_____

Return this form to: privacy@mfars.org

Morganville First Aid and Rescue Squad, Inc. PO Box 310, Morganville NJ 07751

There is no charge for a requested accounting in any 12-month period. However, there is a reasonable fee based upon costs for any subsequent request within the 12-month period.