Attachment C

Request for Restrictions on the Use and/or Disclosure of Protected Health Information

I understand that I have the right to request a restriction or limitation on the health information CMU uses or discloses about my treatment, payment for my treatment services, or in the assessment and improvement of its business and clinical operations.

I understand that CMU is **not required to agree to my request,** however, if my request is granted, CMU will comply with the request unless the information is needed for emergency treatment.

Request Date: _____
Name: _____
Address: _____
_____
Telephone: _____

1. What information do you want to limit or restrict?

_____
_____
_____
_____
_____
_____
_____

2. Do you want to limit how CMU can use the information, or CMU's disclosure to others or both?

_____
_____
_____
_____

_____ _____
Client/Patient/Employee Signature Date

_____
Guardian Signature, if appropriate

_____
Relationship to Client

Revised as of 4/7/03

Attachment C

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(For office use only)

___ Request Denied ___ Approved as Requested ___ Approved Per Comments

Comments:
____
____
____
____
____
____
____

Privacy Officer Signature: ________________________________ Review Date: ______________________

PO Job Title: _________________________

Client Informed in Writing: Yes ___ Contact Date: ______________________