

Request for Restrictions on Use & Disclosure

Individual Name: _____

Individual Address: _____

Individual Date of Birth: _____

Individual SSN: _____

Specimen ID # (if known) _____

Please consider this a request for the exercise of my rights under federal and state laws to request confidential communication of my Protected Health Information

Please explain below how, specifically, you want the use or your protected health information restricted IN OUR PRACTICE.

1. *What information do you want restricted?*

2. *Who is restricted from accessing this information?*

Please explain below how, specifically, you want your protected health information restricted from DISCLOSURE TO OUTSIDE ENTITIES?

1. *What information do you want restricted (not disclosed)*

2. *Who is restricted from accessing this information?*

I understand that the provider to whom I am making this request will make reasonable efforts to accommodate this request. I understand the provider is not required to honor this request when information about me is needed for emergency treatment or in various circumstances when the information is permitted, by law, to be released. I further understand that the provider may terminate this restriction and I will be informed of the termination. I may choose to terminate this restriction by giving notice of such termination to provider in writing.

Signature: _____ *Date:* _____

Please Mail Form to:

Clinical Reference Laboratory, Inc. Attn: Privacy Officer, 8433 Quivira Road Lenexa, KS 66215