CLINICAL REFERENCE® LABORATORY

REQUEST FOR RESTRICTIONS

Effective date of this notice: 04/16/2020

Individual Name: _____
Individual Address _____
Date of Birth: _____
SSN or ID No: _____
Specimen Identification No: _____

Please consider this a request for the exercise of my rights under federal and state laws to request restriction of my Personal Information

Please explain below how, specifically, you want the use or your personal information restricted.	
Describe the Personal Information you want restricted	
What restrictions do you want applied?	
Who is restricted from accessing this information?	

Please explain below how, specifically, you want your personal information restricted from DISCLOSURE TO OUTSIDE ENTITIES?	
What information do you want restricted? (not disclosed)	
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

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Clinical Reference Laboratory, Inc. - 8433 Quivira Road - Lenexa, Kansas 66215
913-492-3652 - 800-445-6917 - FAX 913-492-4308