NEW PATIENT REGISTRATION FORM

REQUEST FOR RESTRICTIONS ON USE AND DISCLOSURE

Patient Name: _____ **DOB:** _____

I understand I have the right to request restriction(s) as to how my Protected Health Information may be used and/or disclosed to carry out treatment, payment or health care operations or disclosed to family members and others involved in my care. I understand that Lafferty Family Care is not required to agree to the restriction(s) requested but will accommodate reasonable requests whenever feasible. If we agree to a requested restriction, it will be binding except in the case of emergency treatment or as required by law. You may end the restriction(s) at any time by notifying us in writing. A signed, dated copy of this Request shall be as effective as the original.

List individuals you **want** information disclosed to: (1) _____

(2) _____ (3) _____

List type of information or records you **want** disclosed: (1) _____

(2) _____ (3) _____

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

SIGNATURE/RELATIONSHIP OF PATIENT'S REPRESENTATIVE DATE

FOR OFFICE USE ONLY

☐ Accepted ☐ Denied ☐ Delayed	If accepted, state which of the restriction(s) accepted: If denied, state which restriction(s) were denied:
Signature of Privacy Officer	Date

Lafferty
Family Care
With You. For Life.