REQUEST FOR RESTRICTION OF USE OR DISCLOSURES OF HEALTH INFORMATION

LINDA I. SODOMA DO, PLC

Patient name·_____ Date of Birth _____

Previous name _____

_____ has my

Name/Relationship

permission to inquire about and receive information pertaining to my Protected Health Information (PHI).

This consent shall remain in effect until revoked or until: _____

Date

OR

I request that this office restrict the disclosure or use of my Protected Health Information (PHI) to certain individuals or for certain purposes as described below:

_____

_____

_____

_____

_____ _____

Signature of patient or legally authorized individual Date

_____ _____

Printed Name if signed on behalf of the patient Relationship to patient