COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
REQUEST FOR RESTRICTIONS ON THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Individual's Name: ______________________ Birth Date: ______________________

Recipient Number: ____

Individual's Address: ____

How would you like the use and disclosure of your protected health information restricted? Explain.

______________________________________ ______________________

Signature of Individual or Personal Representative Date

FOR DEPARTMENT USE ONLY:

Date Received: __________________ Restriction has been: ☐ Accepted ☐ Denied

If accepted, type of Restriction.

If denied, explain why: