RESET

pennsylvania
DEPARTMENT OF HUMAN SERVICES

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: