



MR# / SSN: _____

REQUEST FOR RESTRICTION OF PROTECTED HEALTH INFORMATION

In completing this form, you are requesting the following restrictions to be considered as limitations to Palmetto Health's Use and Disclosure of your Protected Health Information. Palmetto Health is not required to agree to restrictions, Palmetto Health is required to accept requests for restrictions. If we agree to your request, we are bound by the terms of the agreement. You will be notified in writing of Palmetto Health's decision to accept or deny your request for restriction. Until a decision is reached, your request for restriction will be honored.

REQUESTED RESTRICTIONS: (Please provide specific dates and details)

Print Name: _____

Address: _____

Telephone Number: _____

**Signature of Patient
Or Legally Qualified
Representative:** _____

Date: _____

Relationship to Patient: _____

Palmetto Health:

___ **Accepts Requested Restriction**

___ **Denies Requested Restriction**

Palmetto Health Signature: _____

Department: _____

Date: _____