

## **Request for Restriction on Uses and Disclosures of Protected Health Information**

I understand that I have the right to request restrictions as to how my protected health information is used or disclosed for purposes of carrying out treatment, payment or health care operations. Clifford Beers is generally not required to agree to my requested restrictions, but if Clifford Beers does agree to such a restriction, the restriction is binding on Clifford Beers, except as needed to provide me with emergency treatment.

Please indicate your requested restrictions of uses and disclosures of your protected health information.

- ☐ I request the following restrictions on the use and/or disclosure of my protected health information for purposes of carrying out treatment, payment or health operations: \_\_\_\_\_

\_\_\_\_\_

- ☐ I request the following restrictions on the use and/or disclosure of my protected health information for purposes of the facility directory:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- ☐ I request the following restrictions on the disclosure of my protected health information (including my location and general condition, or death) to a family member, relative, or close friends directly involved in my care or the payment of my care:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<i>To be completed by Clifford Beers:</i>
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Requested Restriction(s):

- ☐ Accepted  
☐ Denied