Print Form

# REQUEST FOR RESTRICTION
# OF PATIENT HEALTH CARE INFORMATION

Patient's Name:_____

Address:_____

Date of Birth :_____ Date of Request:_____

I hereby request Brant L. Gerckens D.C. to restrict the release and disclosure of the following health care information contained in my medical record:

___ History of injury, illness or condition for which I am being treated.
___ Previous history unrelated to the condition for which I am being treated.
___ The following examination findings: _____
___ The diagnosis of_____
___ The following test results _____
___ The following medication(s)_____
___ The following treatment(s) _____
___ The following medical recommendation(s)_____
___ Other: _____
_____

I request the information listed above to be restricted to the following person(s) or entity _____
from (date) _____ to (date) _____

**I understand that I have a right to terminate this request either verbally or in writing.**

**I also understand that Brant L. Gerckens D.C. has the right to decline my request to restrict the disclosure of my protected health information.**

_____ _____
*Signature of Patient* *Date*