MMP

MID-MICHIGAN PHYSICIANS, P.C.

7.70 Patient Request for Restriction of Protected Health Information

I, the undersigned, am requesting a restriction on the use and/or disclosure of my protected health information. I understand that Mid-Michigan Physicians, P.C. is not obligated to agree to the restriction and may, therefore, deny my request. I also understand that a copy of this request and any subsequent agreement, disagreement, or termination will be maintained as part of my medical records as required by the Privacy Rule.

Mid-Michigan Physicians, P.C. also has the right to terminate this restriction, if they agree to it, at any time. If terminated, an agreed to restriction will not apply to any protected health information obtained after the date of a termination. A copy of any termination will be maintained in my medical record as required by the Privacy rule.

This request will identify what protected health information I want to restrict, which persons and/or entities I want to be restricted from receiving the protected health information.

Protected Health Information to be Restricted (please list the information you want restricted)

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Entities Restricted from Receiving the Protected Health Information (please identify those who should not receive the information)

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patient name

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patient signature date