

Raleigh Pediatric Associates, PA

REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF HEALTH INFORMATION

I, the undersigned, do hereby request Raleigh Pediatric Associates to restrict the use or release of health information concerning _____, DOB _____, for the time period of _____ to _____ as follows:

1. Name and address of person or entity to whom I do not want health information disclosed: _____

Description of health information I do not want disclosed to this person or entity:

2. Name and address of person or entity to whom I do not want health information disclosed: _____

Description of health information I do not want disclosed to this person or entity:

3. Name and address of person or entity to whom I do not want health information disclosed: _____

Description of health information I do not want disclosed to this person or entity:

I understand that Raleigh Pediatric Associates is not required to agree to any of my requests, except for requests that my child's health information not be provided to any third party payor for payment or operations purposes where I have already paid for the costs associated with my child's care and treatment out of pocket in full. For all other requests for restriction, if Raleigh Pediatric Associates does agree it will comply with my requested restriction(s) unless the information is needed to provide my child with emergency treatment. Raleigh Pediatric Associates and I each have the right to end the restriction at any time upon written notice to the other; however, Raleigh Pediatric Associates will not be permitted to disclose to a third party payor any health information about care or treatment, the costs for which I have already paid for in full and out of pocket (without resort to my third party payor).

Signature of Patient or Authorized Party

Date

Relationship to Patient

Printed Name