REQUEST FOR RESTRICTION

ChristianaCare Privacy Office
4000 Nexus Drive
Avenue North – Suite NW3-100
Wilmington, DE 19803
Telephone No.: (302) 623-4468
Fax No.: (302) 428-2475

MR# ____

Complete this form when an individual requests a restriction to the use and disclosure of their protected health information.

**PLEASE COMPLETE ONE FORM FOR EACH RESTRICTION REQUESTED **

Restrictions must be approved. You will be informed in writing regarding the status of your request.

Patient/Member Name: (print)____________________________________Date of Birth:______________________

Address:______________________________City: _________________________ State:________ Zip:_________

Email Address:____

A) I wish to restrict the following individual(s) and/or entities from obtaining my information (specify):

Name	Relationship (e.g., mother, Power of Attorney)

B) I wish to restrict the use/disclosure of the following documents/records (specify):

Date(s) of Visit	Document Name

Timeframe for the restriction:_____________________________________

Why are you requesting a restriction?____

____

____

____ _____________or

Signature of Patient/Member Telephone No. Date

Signature of Legal Representative & Relationship to Patient/Member | Telephone No. | Date