County Ambulance, Inc.
Patient Request for Restriction Form

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security No.: _____

Patient Rights: As a patient, you have the right to request restrictions to the uses and disclosures of your PHI. **County Ambulance, Inc. is not required to agree to any restrictions requested by the patient, however any restrictions agreed to by County Ambulance, Inc. are binding on County Ambulance, Inc. .**

Please indicate your request for restricted uses and disclosures of your PHI.

_____

_____

_____

_____

Signature _____ *Date*_____

FOR AMBULANCE SERVICE USE ONLY

DATE REC'D _____

REQUEST ACCEPTED _____

REQUEST DENIED _____

DATE _____

REVIEWING OFFICIAL _____

NOTICE TO PT _____

COMMENTS: _____

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