Ascension Saint Agnes

Request for Privacy Restrictions Request Form

Please complete the following information:

1. Today's date: ____
2. Patient Full Legal Name ____
3. Patient Street Address ____
4. City, State and Zip ____
5. Patient Social Security # (**last 4 digits only**) _________________________________
6. Patient Birth Date ____
7. Date associated with information to be restricted (*e.g.*, date of office visit, treatment, or other health care services).

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8. Describe the information to be restricted (*e.g.*, lab test results, physician notes)

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9. What is your reason for making this request? (Optional)

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10. Signature of patient/patient's legal representative

____Date: ____________________

Forward to:

Privacy Officer
Phone number
Address