Request for Restriction of Use and Disclosure

Date of Request: _____

Patient/Individual

First Name | Middle Initial | Last Name | Date of Birth

Phone Number (with area code) | Email Address (optional)

Requestor (if different from Patient/Individual)

Written permission/documentation must be on file for a party to make a request on the patient's behalf.

First Name | Last Name | Relationship to Patient

Phone Number | Email Address (optional)

Restriction Type and Time Period

I am requesting Colorado Physician Partners to restrict communication and/or the use and disclosure of my health information as explained below:

Your Right to Request Restrictions

- You have the right to request restrictions on the communication and/or the use and disclosure of your personal health information held in Colorado Physician Partner records.
- We will consider your request, but we do not have to agree to your request. We will notify you of our decision. Your request and the response will be kept in your record.
- If Colorado Physician Partners agrees to your request, the restricted information will not be used or disclosed.

Review and Sign

I acknowledge that I have read all of the information on this form.

Signature of Individual or Individual's Legally Authorized Representative **Date**

X_____ _____

Please send this completed form by mail or email to:

Attn: Privacy Officer
Physician Health Partners
PO Box 13406
Denver, CO 80202-9998

Privacy@Alpine-Physicians.com