REQUEST TO RESTRICT USE AND DISCLOSURE OF HEALTH INFORMATION

By completing this request, you are requesting the following restrictions be considered as limitations to Reading Hospital, use and disclosure of your Protected Health Information (PHI). If your request is granted, Reading Hospital will not use or disclose information that you have restricted.

You will be notified in writing of the decision to grant or deny your request within 30 days. Until a decision is reached, your request for restriction will not be honored.

REQUESTED RESTRICTIONS (Please provide specific details and dates of service)

Details	Dates of Service
1.	
2.	
3.	

PRINT PATIENT NAME _____ DATE OF BIRTH _____

X _____ PATIENT SIGNATURE OR AUTHORIZED REPRESENTATIVE _____ DATE

White Copy: Director, Health Information Management Yellow: Patient Copy