OREGON MEDICAL GROUP

REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION

Patient Name: _____ Phone Number: _____ (Home)

Date of Birth: _____ _____(Other)

Patient Address: _____
(Street or PO Box)

_____
(City) (State) (Zip)

1. Medical Information to be Restricted: _____

_____

_____

2. Nature of Restriction: _____

_____

_____

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3. Medical Information to be Communicated Confidentially: _____

_____

4. Alternative Location/Address/Telephone Number/E-mail: _____

_____

TO OUR PATIENTS: You may request that we restrict our use and disclosure of your medical records and information. Although the law does not require us to agree to your requested restrictions, if we do agree to the requested restriction, we will abide by the restriction unless a medical emergency or law requires otherwise. You also have the right to request that we communicate certain medical information to you in confidence. We will accommodate your reasonable written requests to receive communications of medical information by alternative means or at alternative locations only if you (1) specify the alternative location, address, or telephone number and/or the alternative means of contact and (2) agree to be responsible for and explain how payment will be handled for any additional costs associated with the alternative method of communication.

***By your signature below, you acknowledge that you understand and agree to the above information*.**

Signature of Patient _____ _____ Date

Completed form may be returned to PO Box 1648 Eugene, OR 97440

__ Request for Restriction **ACCEPTED**
__ Request for Restriction **DENIED**

__ Request to Communicate Confidentiality **ACCEPTED**
__ Request to Communicate Confidentiality **DENIED**

Reason for Denial: _____

Physician Signature: _____ Date: _____

HIPAA Privacy Officer Signature: _____ Date: _____

[ ] Patient notified of decision