



Use this form to request a restriction of our use and disclosure of protected health information (PHI) that we, or our business associates, maintain for treatment, payment or health care operations.

Please complete the following:

NAME		DAYTIME PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH	CONTRACT NUMBER		

Please read and complete the following:

You have the right to request that we restrict our use and disclosure of your PHI for treatment, payment and health care operations. We are not required to grant your request. If we do, our agreement will be in writing and we will restrict our use and disclosure of your PHI as you request. We may, however, use and disclose the restricted information in appropriate medical emergency situations, or when use or disclosure without your written permission is authorized or required by law.

You can terminate the restriction at any time by notifying us in writing. We can also terminate our agreement to a restriction at any time by notifying you in writing. If we do, termination is effective only to your PHI that we create or receive after we gave you our written notice terminating the restriction.

To exercise your right to request a restriction on our use or disclosure of your PHI, please specify the PHI that you want handled in a restricted fashion, and the restrictions you want us to apply:

Please sign and date:

I request that you restrict the use and disclosure of my PHI as specified above. I understand that you are not required to agree to my request, (but if you do, you will inform me of any termination of the restriction in writing).

Signature: _____ Date: _____

*If you are not the patient, please sign and write today's date below, then check the box that describes your relationship to the patient. If you are not the parent of the patient, please attach proof of your relationship to the patient. **NOTE: An authorization is required if you are not the personal representative.***

Print Name of Personal Representative: _____

Signature of Personal Representative: _____ Date: _____

Parent Legal Guardian Power of Attorney Executor Other _____

Please return this form to the Family Health Center where you receive your care:

Family Health Center – Creyts Road 1401 S. Creyts Road Lansing, MI 48917	Family Health Center – Lake Lansing 1525 W. Lake Lansing Road East Lansing, MI 48823	Former patients of Fashion Square, Essexville, and Midland Family Health Centers return forms to: Family Health Center – Creyts Road 1401 S. Creyts Road Lansing, MI 48917
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