HEALTH CARE SYSTEM
REQUEST FOR RESTRICTIONS FOR USE AND DISCLOSURE OF PHI

Patient Name: _____ *Medical Record Number:* _____

Date of Birth: _____ *Phone Number:* _____

Patient Address: _____

I request that Flexogenix, Inc. restrict the use or disclosure of protected health information about me in the manner described here (please be specific, i.e. the information to be restricted, dates of creation of the information, how you wish Flexogenix, Inc. to restrict its use or disclosure of the information, the reason for request):

_____

_____

_____

I understand that Flexogenix, Inc. is **not** required by law to accept my requested restrictions, but if accepted, Flexogenix, Inc. agrees to abide by the restrictions, except in emergency situations. I also understand that any accepted restriction is not effective to prevent uses or disclosures which are: permitted or required by law without my authorization or the opportunity to object, requested by the Secretary of the Department of Health and Human Services, for directory purposes (unless I have objected to being included in the directory), or uses or disclosures made prior acceptance date.

I understand that if this request is accepted and put into place, it may make the provision of care to me more difficult and/or less effective.

I understand that either Flexogenix, Inc. or I may terminate this restriction in writing at any time in the future. If Flexogenix, Inc. terminates its agreement to the restriction, I understand I must either agree in writing or orally to the termination, or Flexogenix, Inc. may inform me of the termination and make it effective only for protected health information created or received after it has informed me of the termination.

_____ _____ _____

Signature of Patient or Authorized Representative *Date* *Time*

If signing as authorized representative, describe authority to act for patient and submit documentation showing such authority: _____

FLEXOGENIX, INC. USE ONLY

Date request received: _____

Circle one: Accepted Denied

If denied, state reason for denial: _____

Signature of staff member: _____ *Date/Time:* _____

Staff Member (Print Name): _____