

Choices Counseling & Resource Center, P.A.

Request for Restricted Use/Disclosure of Records

The purpose of this form is to request that a restriction be placed on how the client's medical records maintained at Choices Counseling & Resource Center, P.A. are used or disclosed. Upon receiving your request, the information will be reviewed and a decision letter will be sent to you or the person designated.

Request restrictions for the records of

Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ DOB: _____

Your relationship to client: Self Parent/legal guardian Legal representative
 Other (describe) _____

Please describe the restrictions you desire for the use/disclosure of these records. Include the reasons for the restrictions.

I authorize the above-listed restrictions.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ Date: ____/____/____

Parent/guardian/legal representative (if applicable)

Signature: _____ Date: ____/____/____

Witness (if client is unable to sign):

Signature _____ Date: ____/____/____