

DANVILLE RESCUE SQUAD

Patient Request for Restriction Form

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security No.: _____

Patient Rights: As a patient, you have the right to request restrictions to the uses and disclosures of your PHI. **DANVILLE RESCUE SQUAD is not required to agree to any restrictions requested by the patient, however any restrictions agreed to by DANVILLE RESCUE SQUAD are binding on DANVILLE RESCUE SQUAD.** Please indicate your request for restricted uses and disclosures of your PHI.

Signature _____ Date _____

FOR AMBULANCE SERVICE USE ONLY

DATE REC'D _____

REQUEST ACCEPTED _____

REQUEST DENIED _____

DATE _____

REVIEWING OFFICIAL _____

NOTICE TO PT _____

COMMENTS:

