THE MAXWELL GROUP

PATIENT REQUEST FOR RESTRICTION/DISCLOSURE
ON PROTECTED HEALTH INFORMATION (PHI)

Patient Name:____

Patient Address:____

Date of Birth:___________________________________

DISCLOSURE RESTRICTED

Please explain below how specifically you want the use of you health information restricted.

A. What information do you want restricted? _________________________________
____
____

B. Who is restricted from accessing this information? _________________________
____
____

DISCLOSURE PERMITTED

Please explain below how specifically you want the use of you health information disclosed.

A. What information do you want disclosed? _________________________________
____
____

B. Who do you want you health information disclosed to? ______________________
____
____

I understand that The Maxwell Group is not required by law to accept my requested restrictions, but if the practice does, The Maxwell Group agrees to abide by the restrictions except in emergency situations or as otherwise provided by law.

I understand that either The Maxwell Group or I may terminate this restriction in writing at any time in the future.

____ ________________
Signature of Patient or Legal Representative Date

____
Description of Legal Representatives Authority