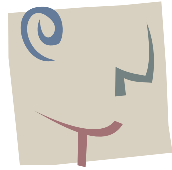

Ear, Nose & Throat Center

Request for Restriction of Protected Health Information

Patient Name: ______________________________

Date of Birth: ______________________________ Chart Number: ______________________________

I am requesting that the *Ear, Nose & Throat Center* restrict the disclosure of some of my protected health information.

Information I wish to restrict: ______________________________

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Entities/Individuals to whom the restriction applies: ______________________________

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Do not disclose this information for the following reason(s): ______________________________

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Please be aware that the Ear, Nose & Throat Center is not required to agree to your request of non-disclosure pertaining to treatment, payment, and health care operations. If we agree to your request, this information may still be used and/or disclosed in order to provide emergency treatment.

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Signature Date