CHIPPEWA COUNTY HEALTH DEPARTMENT

RESTRICTIONS on USE and DISCLOSURES of HEALTH INFORMATION

Patient's Right to Request Restrictions on Uses and Disclosures

Please complete this form to request restrictions on the use or disclosure of your health information.

I, _____ request that Chippewa County Health Department restrict its use or disclosure of:___ my health information, or ___ the health information of _____ for whom I am the personal representative.
(Patient name)

I request the following restriction(s):

_____

_____

I request restriction(s) for the following reason:

_____

_____

I understand that, if this requested restriction is accepted, Chippewa County Health Department may not necessarily comply with it if I am **[or the patient is]** in need of emergency treatment.

Signature of requestor: _____

Date of request: _____

If the requestor is the patient's personal representative, relationship to patient:

_____