PULMONARY AND CRITICAL CARE ASSOCIATES OF BALTIMORE, P.A.

Request for Restriction of Use or Disclosure of Health Information

I_____, request that PCCAB restrict the use or disclosure of my protected health information for the purpose of treatment, payment, or health care operations, or regarding a person involved with my health care, in the following manner:

Describe requested restriction below:

_____
_____
_____
_____
_____
_____

I understand that if I am in need of emergency treatment and the restricted information is necessary for the provision of emergency treatment that PCCAB may disclose the information to provide the emergency treatment.

Signature: _____ Date: _____

D.O.B. _____

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For Privacy Officer Use Only

Upon reviewing Patient's Request for Restriction, Pulmonary and Critical Care Associates of Baltimore, P.A.,

_____ Agrees to Patient's Request for Restrictions

_____ Does not agree to Patient's Request for Restrictions

Date: _____ Signature: _____

_____ Mailed to patient

_____ Copy to patient in office