UROLOGY CENTER OF COLUMBUS, L.L.C.

# Request for Restriction of Use and Disclosure of Protected Health Information

Patient Name: _____

Date of Birth: _____

Patient Address: _____
Street City, State Zip

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**Requested Restriction**
What PHI would you like restricted: _____

_____

_____

_____

Please describe you would like the PHI to be restricted: _____

_____

_____

_____

**Note: The practice is not required to agree to your request. Please see our notice of privacy practices for more information regarding such requests. In addition, our practice may terminate this agreement to restriction based on the following:**

- You agree to or request a termination in writing
- You orally agree to the termination and the oral agreement is documented, or
- Our practice informs you that we are terminating the agreement. We will only be able to use or disclose protected health information that is created or received after the restriction agreement is terminated.

_____ _____
Patient Signature or Personal Representative Date

*Office Use Only*

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- ❑ **We hereby accept the above restriction of PHI.**
- ❑ **We hereby deny this request for restriction of PHI.**

_____
**Practice Representative's Name (Type/Print)**

_____
**Practice Representative's Signature**

_____
**Date**