Request to Restrict Health Information Disclosures

Please complete and return this form to a Department of Health and Welfare office.

Available in Spanish. We provide interpreter services at no cost. Call 2-1-1 or 1-800-926-2588 for interpretation assistance.
Disponible en espanol. Proveemos servicios de intérprete sin costo alguno. Llame al 2-1-1 ó al 1-800-926-2588 para obtener la ayuda de un intérprete.

Client Name____ Client Date of Birth ____________________
(First, MI, Last)

Client Home Address ____

Client Mailing Address (if different) ____

Client Telephone ______________________________

Requestor Name (if different than client) ____

Requestor Telephone ___________________________ Requestor Fax Number (optional) _______________

Please list where you would like us to send our response to your request.

Name ____

Address ____

The health information that I would like to restrict from disclosure: ______________________________

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The person or business I would like to restrict from receiving the information: _______________________

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Time period for which I would like this restriction on health information to be effective: ______________________

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If the Department agrees to your request, we will comply unless the information is needed to give you treatment, or until you terminate the restriction.

I understand that I may request to terminate this restriction at any time by completing and submitting the proper Department form. A Request to Terminate a Health Information Restriction form is available at Department offices.

The Department will notify you in writing if we are unable to respond to your request within 10 days.

If this request is being made by someone other than the subject of the information, please describe and provide documentation of your authority to request to restrict health information disclosures for that person ________________

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Your signature ____________________________________ **Date requested** ________________

Your signature must be notarized if you submit this request by mail or fax.

I, ________________________________, being a Notary Public, do hereby certify that on this day ____________ of __________________, 20_______, the above individual, having been first duly sworn, appeared before me and signed the foregoing document.

____
Signature of Notary Public

Notary Public residing at ________________________________
My commission expires on ________________________________

For DHW Office use only
- ○ ID Provided __________
- ○ Form Complete _______

Authority:
- ○ Accessing own records __________
- ○ Documentation Attached ___________
- ○ Not Required _________