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**REQUEST FOR RESTRICTION ON USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION (PHI)**

Patient Name: _____ DOB: _____

I, _____ request that West Ridge Obstetrics & Gynecology, LLP restrict the use or disclosure of my Protected Health Information (PHI) described below when carrying out my treatment, or obtaining payment for my treatment, or when carrying out the Practice's health care operations. The restriction requested is described below:

1. Description of PHI to be restricted: _____

2. Family Member and/or Person(s) restricted from access to PHI:

3. Family Member and/or Friend access to PHI: I request that West Ridge Obstetrics & Gynecology, LLP restrict the disclosure of my Protected Health Information (PHI) so that **ONLY** the family member, other relative or close personal friend herein named who is involved with my care or the payment for my care **MAY** have access to my Protected Health Information (PHI):

Practice Response. I understand that West Ridge Obstetrics & Gynecology, LLP is not required by law to accept my requested restrictions, but if the Practice does, West Ridge Obstetrics & Gynecology, LLP agrees to abide by the restrictions except in emergency situations.

Termination. I understand that West Ridge Obstetrics & Gynecology, LLP may agree to a restriction and may also, in the future, terminate its agreement, but such termination will only be effective with respect to Protected Health Information (PHI) created or received after I have been notified of the termination.

Signature of Patient/ Representative/ or Legal Guardian

Date

Witness

Date

FOR PRACTICE USE ONLY

West Ridge Obstetrics & Gynecology, LLP Hereby: AGREES DOES NOT AGREE TO THIS REQUEST

Reason for Rejection: _____

Privacy Officer Signature: _____ Date: _____

Date Noted in System: _____ Initials: _____ Date Scanned in System: _____ Initials: _____