Polson/ Ronan Ambulance
Patient Request for Restriction Form

Patient Name: ___________________________________ Date: _____________

Address: ____

City: ______________________ State: ______________ Zip Code: _________

Social Security No.: ________________________________

Patient Rights: As a patient, you have the right to request restrictions to the uses and disclosures of your PHI. **Polson/ Ronan Ambulance is not required to agree to any restrictions requested by the patient; however, any restrictions agreed to by Polson/ Ronan Ambulance are binding on Polson/ Ronan Ambulance.**

Please indicate your request for restricted uses and disclosures of your PHI.

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Signature ___________________________________ *Date*___________________

FOR AMBULANCE SERVICE USE ONLY:
DATE REC'D ________________________
REQUEST ACCEPTED ________________
REQUEST DENIED __________________
DATE ________________________________
REVIEWING OFFICIAL _______________
NOTICE TO PATIENT ________________

COMMENTS:____

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