

**Bangs Ambulance, Inc.**  
**Patient Request for Restriction of Protected Health Information**

Patient Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

***Right to Request Restrictions Regarding Your PHI and Our Duties:***

You (or your authorized representative) have the right to request that we restrict how we use or disclose your PHI for treatment, payment or healthcare operations, or to restrict the information that is provided to family, friends and other individuals involved in your healthcare. However, we are only required to agree to a requested restriction when you ask that we not release PHI to your health plan (insurer) about a service for which you have paid Bangs Ambulance, Inc. in full. We are permitted, but not required, to agree to other requested restrictions. But, we are required to abide by any restrictions that we have agreed to honor.

***Request for Restriction of PHI:***

Below, please explain your request for restricted uses and disclosures of your PHI. Please indicate for what purposes you would like to restrict the PHI and specific parties to whom you would like us to not provide PHI. Bangs Ambulance, Inc. will consider your request and promptly let you know whether or not we agree to your requested restriction(s).

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***Signature of Requestor:*** \_\_\_\_\_ ***Request Date:*** \_\_\_\_\_

***Requestor Information (if requestor is different from patient):***

Name: \_\_\_\_\_

Relationship to Patient (parent, legal guardian, etc.): \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

