

## Restriction Request Form

Neurology Associates, Inc.  
1034 S. Brentwood Blvd., Ste 754  
St. Louis, MO 63117  
ph: (314) 725-2010 fax: (314) 725-0709

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Phone Number

\_\_\_\_\_  
Patient Birthdate

\_\_\_\_\_  
Patient SSN

**I understand that the information contained in my medical record:**

- Serves as an important tool in the course of my health care and is used and disclosed to carry out treatment, payment, or health care operations.
- May be used to provide a source of communication among health care professionals and among those involved in my care in order to provide me the best treatment possible.
- May be used by insurance companies in order to verify services billed and as a foundation to assess the quality of care provided to me.

Neurology Associates, Inc. will review my request for restrictions. I understand that Neurology Associates, Inc. does not have to accept my request, but that if they do, it is legally binding. I understand that the following restrictions may be terminated at any time by either myself or Neurology Associates, Inc. I also understand that a request to restrict my protected health information from other entities could pose a danger to myself in receiving future treatment.

**I request that the following restrictions be placed on the use or disclosure of my health information:**

(You may list specific persons and/or specific ways in which you do not want your information disclosed)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

-----**FOR OFFICE USE ONLY**-----  
Date received: \_\_\_\_\_

Request for Confidential Communications has been:

- Accepted.  
 Denied.

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Privacy Officer

\_\_\_\_\_  
Date