Memorial Healthcare

Request for Restrictions of Uses and Disclosures

Patient name (print):_____D.O.B_____

Medical record #: _____Account#:_____

If you (or your representative) pay in full and out of pocket for a healthcare service or product we provided, and you request that we not disclose that information to your health plan, please check here [ ].

Please describe the information you want limited and to whom the restriction applies:_____

_____

_____

_____ _____

Patient Name (Please Print) **Date**

_____ _____

Signature of Patient or Legal Representative **Date**

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Request of Revocation of Restrictions for Uses and Disclosures

I wish to revoke the above request for restrictions for uses and disclosures.

Reason to Revoke Restrictions for Uses and Disclosures: _____

_____

Patient Name (Please Print) **Date**

_____ _____

Signature of Patient or Legal Representative **Date**

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Submit Form To:
Chief Privacy Officer
Memorial Healthcare / 826 W. King St. / Owosso, MI 48867

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Hospital use only:

Patient notified date: _____

Request for Restriction: *( ) Accepted* *( ) Denied*

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Scan this form in the correspondence section of the Medical Record when complete