Boulder Community Health

Patient Name: _____ DOB: _____
Address: _____ Phone: _____
Admission Date: _____ MR #: _____ Account #: _____

I hereby request a privacy restriction on the use and/or disclosure of my health information in a manner described below. I understand that Boulder Community Health ("BCH") may deny this request. I also understand that if agreed to, BCH may not be able to honor this request if I require emergency treatment. Additionally, I understand BCH may terminate the agreement to a restriction as long as I am informed.

I REQUEST THE FOLLOWING PRIVACY RESTRICTIONS:

1. Date associated with information to be restricted (i.e., date of office visit, treatment, or other health care service):

_____

2. Describe the information to be restricted (i.e., lab test results, physician notes):

_____
_____
_____
_____
_____
_____

3. What is your reason for making this request? (optional):

_____
_____
_____
_____

4. I request that the following person(s) and/or organization(s) not be allowed to use and/or disclose the health information described above:

_____
_____
_____

Signature of Patient: _____ Date: _____

or Legal Representative: _____ Relationship to Patient: _____

Note: Legal representative documentation must accompany this form.

Place Label Here