BERKS COUNTY

REQUEST TO RESTRICT USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. **Client Name:** _____

2. **Date Of Birth:** _____

3. **Description of the Health Care Information to be Restricted:**

   _____

   _____

   _____

4. **Description of the Restriction Being Requested Related to Use or Disclosure of the Above Information:**

   _____

   _____

   _____

5. **Description as to the Time Period Client Requests the Restriction:**

   _____

   _____

   _____

6. **Other Information:**

   _____

   _____

   _____

Office Use Only

Request received for review	_____	_____
	Date	**Signature**
Determination made	_____	_____
	Date	**Signature**
Determination communicated to Client	_____	_____
	Date	**Signature**
Documented	_____	_____
	Date	**Signature**
Restriction communicated to appropriate staff	_____	_____
	Date	**Signature**