WPCS WESTERN PSYCHOLOGICAL & COUNSELING SERVICES, P.C.

Request to Restrict Use or Disclosure of Protected Health Information

Date of Request: _____

Client Name: _____ Date of Birth: _____

Phone #: _____ ☐ Cell ☐ Home ☐ Work Ok to leave Message? ☐ Yes ☐ No

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I request that Western Psychological and Counseling Services (Western) restrict the use or disclosure of health information as described below.

I understand that Western is not required to agree to my request. Even if Western does agree, Western may use or disclose information to get emergency treatment for me or when required by law.

I understand that if my request involves issues about payment for my health care, Western will need to know how payment for services will be made before it will agree to my request.

I would like use and disclosure of the following health information to be restricted: _____

_____

I want this information restricted because: _____

_____

I do not want this information given to the following persons or organizations: _____

_____

If Parent/Guardian, print name: _____ ☐ Parent ☐ Guardian ☐ Other _____

Signature of Client or Parent/Guardian: _____ Date: _____

To Be Completed by Western's Privacy Officer:

☐ Request is granted. Should Western need to end these restrictions, you will be notified

☐ Request is denied for the following reason(s): _____

_____

Date of Determination: _____ Privacy Officer signature: _____