BARBARA ROSE CHATEAUBRIAND, MA
8245 20th Avenue NE #2
Seattle, WA 98115
(206) 525-9745
Licensed Mental Health Counselor #LH00008130

# PATIENT REQUEST FOR RESTRICTION ON USE AND DISCLOSURE OF PHI

I request that Barbara Rose Chateaubriand restricts the use and disclosure of protected health information (PHI) listed below. I understand that Barbara Rose Chateaubriand may not agree to this request; provided, however, that Barbara Rose Chateaubriand may be required by law to grant a restriction preventing disclosure to my health plan concerning services or items for which I have paid Barbara Rose Chateaubriand.

Describe the restriction requested:

_____
_____

_____
_____

This restriction shall be in effect until (date or event):

_____

Patient Name, printed: _____

Signature: _____ Date: _____

Relationship if not patient: _____

Mailing Address for future correspondence regarding this restriction:

_____

_____

_____

Barbara Rose Chateaubriand has reviewed the above request to restrict the use and disclosure of protected health information (PHI) and (check one)
__ Denies the request as Barbara Rose Chateaubriand cannot reasonably assure or guarantee the restriction can be met.
__ Accepts and will honor the request for the above stated restriction with the following exceptions and conditions:

If you need emergency treatment and the restricted PHI is needed to provide emergency treatment, I may use the restricted PHI or may disclose this information to another health care provider to provide you with the emergency treatment.

I will ask the health care provider to not further use or disclose the PHI.

To the extent permitted by law, I may need to terminate or revoke our acceptance of this restriction. Of course, I will notify you of such unilateral termination.

Therapist's Signature: _____ Date: _____

Title: _____

REVOKING OR TERMINATING RESTRICTIONS OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Check One:
____ Patient: I hereby revoke the above restriction of the use and disclosure of my protected health information (PHI) effective _____ (date).
____ Barbara Rose Chateaubriand previously agreed to the above restriction of the use and disclosure of your protected health information (PHI). To the extent permitted by law, Barbara Rose Chateaubriand terminates this previous agreement and no longer will restrict the use and disclosure of your protected health information effective_____ (date).

Signed: _____ Date: _____

Printed Name: _____

Relationship if not patient: _____