HealthEast Care System

Woodwinds Health Campus

INDIVIDUAL TO COMPLETE

Name: _____ DOB: _____ - _____ - _____

Address: _____ Phone #: (_____) - _____ - _____

_____

HealthEast Facility: _____

Information and dates of information not to be released: _____

To whom the information should not be released: _____

Please give a brief description of information you would like restricted:

_____

_____

_____

If this restriction is accepted, the restriction will be enforced until the facility specified as above has been further notified in writing by the individual to revoke their request for restriction.

When HealthEast has agreed to a request for restriction concerning the disclosure of health information to another healthcare provider, and if disclosure of the restricted information would assist in treating the individual in an emergency situation, HealthEast will disclose the information necessary. HealthEast will request that the information not be further disclosed.

_____ _____

(Signature of Individual or Personal Representative) (Date)

_____

(Relationship to Individual)

HEALTH INFORMATION SERVICES (HIS) TO COMPLETE

Medical Record Number: _____ Date Received: _____/_____/_____

Check one of the following:

☐ Restriction Accepted

☐ Restriction Denied

_____ _____

(Signature of Manager) (Date)