Request for Restrictions on Uses and Disclosures of Health Information

You may request a restriction on the use and disclosure of your health information for treatment, payment and administrative activities. HOWEVER, WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST. NO RESTRICTION IS EFFECTIVE UNTIL YOU RECEIVE WRITTEN CONFIRMATION FROM STAMPS HEALTH SERVICES PRIVACY OFFICER.

To submit a request, you must complete this form and return it to: **Privacy Officer, 740 Ferst Drive Atlanta GA 30322.**

This request applies only to the health care provider that you indicate below. If you would like to request a restriction on the use and disclosure of information for more than one office, you must complete a separate form for each provider. There may be a reasonable fee, based upon our costs, to provide this information. **IN EMERGENCY TREATMENT SITUATIONS RESTRICTION AGREEMENTS WILL NOT APPLY.**

Please provide the following information:

Patient Name: _____ Date of Birth: _____

GT ID#: _____Phone number: _____

Address: _____

Please specify the health care provider office from which you are requesting a restriction

_____

_____

_____

Please describe the information to which this request applies (*e.g.*, pregnancy test results).

_____

_____

_____

Please describe how you would like the use and/or disclosure of your health information restricted.

_____

_____

_____

_____ _____

_____ _____

Signature of patient or personal representative Date

_____

If personal representative, authority to act on behalf of patient

FOR INTERNAL USE ONLY

Received by: _____ Date: _____ Time: _____

Disposition:

_____

_____

_____

_____

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_____

Notification made:

By: _____ Date: _____ Time: _____

Method: _____