Stamps Health Services

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. To submit a request, you must complete this form and return it to: **Customer Service Manager, 740 Ferst Drive NW, Atlanta GA 30332.** *However, we are not required to agree to your request. No restriction is effective until you receive written confirmation form the Stamps Health Services Privacy Officer.*

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 provider, 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: _____

GTID#: _____Phone number: _____

Address: _____

Please specify the health care provider that holds the information to which you are requesting an restriction.

Provider Name: _____

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

FOR INTERNAL USE ONLY

Received by: _____ Date: _____ Time: _____

Disposition: _____

_____

Notification made:

By: _____ Title: _____Date:_____ Time: _____

Method: _____