Concentra°

Restriction Request Form

Please Review Prior to Completing: Please see the bulleted content below to know more about what circumstances are applicable for this form's use to limit or restrict protected health information (PHI) from being disclosed.

Patient Name:	Last	First	MI	Maidan	or Other Name
Date of Birth:	Medical Record Number: .				
Address:		City:		_ St:	Zip:
Facility Visited:					
	gree to this restriction request, unless which you have paid in full. We may				
 We may voluntarily agre informing you of the tern 	e to other requests for restrictions. Any nination.	restrictions to which we ha	ave voluntarily a	agreed ma	ay be terminated by
This restriction will not a	pply to any disclosures of PHI which o	ccurred prior to implementa	tion of this requ	lest.	
 Restrictions will not appl 	y when the restricted information is ne	eded for emergency treatm	ent.		
 Restrictions cannot ap 	ply to workers' compensation.				
-	ation of a previous restriction at any tin	ıe.			
I am requesting that Conc					
Place a restriction	Remove a previous restriction on	the use or disclosure of	my protected	health in	formation (PHI):
Date of Service:					
-	nom PHI Should Not Be Disclosed:				
-	nom PHI Should Not Be Disclosed:				
-					Date
Other:		_ Or Parent/Legal Guard	ian/Authorized Pers		Date
Other:Signature of Pat	ient Date	_ Or Parent/Legal Guard			Date
Other:	ient Date	_ Or Parent/Legal Guard Relations Relations	ian/Authorized Pers hip to Patient ed services. Ou	^{son}	
Other:	Date Date Cessing Inform directly to the Concentra medic information (phone number, fax numb equest to the Concentra Privacy Office cy Office, 4714 Gettysburg Road, Mec	_ Or Parent/Legal Guard Relations Relations eal center where you receive er, mailing address) for Cor :	ian/Authorized Pers hip to Patient ed services. Ou	^{son}	
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