COPLEY

528 Washington Highway Morrisville, VT 05661

PH: (802)-888-8350 FAX: (802) 888-8361

Request for Restrictions on Use/Disclosure of Protected Health Information

Patient Name: _____ Birth Date: _____/_____/_____
MM / DD / YR

Address:_____ Telephone #: _____

_____ E-mail:_____

I, _____ am requesting a restriction on Copley's use and/or disclosure of my health information in the manner described below. I understand that Copley may deny this request. I also understand that if agreed to, Copley may not be able to honor this request if I require emergency treatment.

- I am required to pay, in-full, or the majority of the projected amount for my services before they occur or this request will be null and void and my insurance may be billed without notice for services received.

Description of Restriction of the Health Information to be Used or Disclosed.
The following is a description of the specific health information I wish to restrict (Include dates of service):

_____

_____

Persons/Organizations Restricted from Use and/or Disclose Health Information. I request that the following person(s) and/or organization(s), not be allowed to use and/or disclose the health information described above.

_____

_____ _____

_____

By signing this form, I am confirming that the description above accurately reflects my restriction wishes.

_____ Date: _____/_____/_____
Patient/Personal Representative Name (Print)

_____
Signature of Patient/Personal Representative

Relationship to Patient: _____

Office Use Only

Copley has refused this Request due to:
☐ Request was not made prior to Service Date
☐ Full Payment was not received at Time of Date
Patient/Personal Representative Notified of Decision ☐ Yes ☐ No
Patient Notified By: ☐ Phone Call ☐ Letter Mailed

Signature of Copley Staff: _____