Request for Restrictions or Confidential Communication

Patient Name: _____ **Date of Birth:** _____

Address: _____ **Phone #:** _____

City: _____ **State:** _____ **Zip Code:** _____

Do not use or disclose information from/to :

_____

_____

_____

Information Requested To Be Restricted (please be specific):_____

_____

_____

Explanation Why It Should Be Restricted: _____

_____

Would you like to receive medical information at a different location or means? _____

If so, new address_____

Telephone number _____

You have the right to request that Psychiatry Associates of Kansas City, P.A. restrict the use and disclosure of protected health information. Psychiatry Associates of Kansas City, P.A. is not required to comply with the request if it interferes with payment, treatment or operations. If Psychiatry Associates of Kansas City, P.A. agrees with the restriction, it will be honored unless needed for a medical emergency. You also have the right to receive protected health information in a confidential matter. Psychiatry Associates of Kansas City, P.A. will accommodate your reasonable written request; **only** if you provide us with the specific alternative address, telephone number; and, if you agree to be responsible for any additional costs associated with the alternative method of communication.

By your signature, you acknowledge that you **understand and agree to the above information.**

Patient Signature: _____ Date: _____

Patient's Representative: _____ Date: _____

Office Use Only:

Restriction Accepted _____ **Restriction Denied** _____

Alternative Communication Accepted _____ **Alternative Communication Denied** _____

Manager's Signature _____ **Date** _____

Rational for Acceptance/Denial: _____

_____

Patient Sent Notified of Decision On: _____

With Copy/Request to: Notify Others of Accepted Restrictions _____

Explanation Why Restrictions Were Denied _____

Escalation Procedure _____

Restriction End Date: _____ **Notification Sent to Member On:** _____