ALASKA NATIVE MEDICAL CENTER

REQUEST FOR RESTRICTION ON USE AND DISCLOSURE

Patient Name	Date of Birth	Patient Record Number
Patient Address	City, State, Zip	Telephone # Alternate #

I understand I may request a restriction related only to the Alaska Native Medical Center's (ANMC) uses and disclosures of my health information: (i) to carry out treatment, payment, or health care operations; (ii) to my family members, other relatives, or close personal friends, or to other persons I may designate; or (iii) for disaster relief (notification) purposes. I request the following restrictions:

- ❑ Subject to the above understanding, I want ANMC to make reasonable efforts to not disclose my health information for any of the following purposes (Be as specific as possible):

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- ❑ Other Restriction Requests (Please describe and be as specific as possible.):

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I understand that ANMC is not required to agree to my requests. If, however, ANMC does agree to the request, it will abide by this agreement until either ANMC or I terminate the agreement. ANMC is not required to abide by this agreement in the case of an emergency.

This is a complete list of all restrictions requested. All previous restriction requests are obsolete and no longer in effect.

Signature of Patient or Legal Guardian/ Representative	Date and Time:
For Organization Use Only:	
Date and Time Request Received:	Date and Time of Restriction Accepted/Rejected:
☐ Request Accepted	☐ Request Denied
If accepted, state which of the restrictions accepted:	
Name and Title of Staff Member Processing Request:	
Chart # :	Verification Method: