

THE TREATMENT CENTRE FOR THE HEALING ARTS

Restriction Request Form

I understand that my health information is private and that use of my health information must be consistent with the Centre's Notice of Privacy Practices. I also understand that I am entitled to request restrictions on certain uses and disclosures of my health information. I wish to make the following request(s), and understand that each request may be approved or denied by the Clinic Administrator.

Print Name: _____ Date: _____

1)

Client/Patient Signature: _____

Restriction implemented _____

Restriction denied – Reason for Denial _____

Staff Signature: _____ Date: _____

Print Name: _____ Date: _____

2)

Client/Patient Signature: _____

Restriction implemented _____

Restriction denied – Reason for Denial _____

Staff Signature: _____ Date: _____

Print Name: _____ Date: _____

3)

Client/Patient Signature: _____

Restriction implemented _____

Restriction denied – Reason for Denial _____

Staff Signature: _____ Date: _____