



### Request for restriction of medical records

Patient Name: (print) \_\_\_\_\_

Street/PO Box: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

**Information to Restrict:**

Incident No. \_\_\_\_\_

Please indicate your request for restrictions to the uses and disclosures of your protected health information.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please allow 30 days to process this request. Hillsboro Fire & Rescue is not required to agree to any restrictions requested by the patient; however, any restrictions agreed to are binding.

\_\_\_\_\_  
Signature of Patient or Other Person Authorized to Sign for Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Printed Name

<b>FOR HILLSBORO FIRE AND RESCUE USE ONLY</b>			
Date received: _____	Received by: _____	Paid: _____	Check #: _____
<input type="checkbox"/> Approved by EMS office. <input type="checkbox"/> Denied. Reason for denial: _____			
Initials and Date: _____		Referred to: _____	