

Prentke Romich Company

Restriction of Use or Disclosure of Protected Health Information (PHI) Form

I, _____, request that Prentke Romich Company restrict the use or disclosure of my health information for payment or health care operations in the manner described here: (Please be specific)

I understand that Prentke Romich Company is not required by law to accept my requested restrictions, but if it does, PRC agrees to abide by the restrictions except in emergency situations.

I understand that either I or PRC may terminate this restriction in writing at any time in the future.

Patient/Employee Signature: _____
Printed Name and date of birth: _____
Date: _____

Privacy Officer Comments:

Accept this request.

Reject this request. Reason: _____

Patient contacted.