FORM 2518-A

NORTH SOUND MENTAL HEALTH ADMINISTRATION
REQUEST FOR RESTRICTION ON USE & DISCLOSURE
OF PROTECTED HEALTH INFORMATION

Consumer Name: _____

Phone Number (Day): _____

Phone Number (Evening): _____

Street or PO Box: _____

City: _____

State: _____

Zip: _____

1. Protected Health Information to be Restricted:

_____

2. Nature of Restriction:

_____

TO OUR CONSUMERS: You have the right to request that we restrict our use and disclosure of your medical records and information. We do not have to agree to your requested restrictions. If we do agree to the requested restriction, we will abide by the restriction unless a medical emergency requires otherwise.

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

Signature of Consumer: _____ Date: _____

Request for Restriction Accepted: _____ Request for Restriction Denied: _____

Request to Communicate Confidentiality Accepted: _____

Request to Communicate Confidentiality Denied: _____

This Request for Restriction and Confidential Communication Form is to be made a part of the medical record of: _____ (Consumer Name).