Request for Restrictions on Uses and Disclosures
for Treatment, Payment, and Health Care Operations

Help us protect your privacy by filling in the following information and specifying any contact information that you would like to be restricted. Please fill in information where we may contact you. If you do not wish for us to contact you at a specific location please make a note of this on this form. Also, please note if there is a particular way in which we should identify ourselves (e.g., 'Mental Health Professionals', your therapist's name, etc.) should we need to call you.

____ Home Phone Number:_____
How we should identify ourselves:_____
May we say the clinic name: _____Yes _____No

____ Work Phone Number:_____
How we should identify ourselves:_____
May we say the clinic name: _____Yes _____No

____ Other Phone Number:_____
How we should identify ourselves:_____
May we say the clinic name: _____Yes _____No

Other restrictions:

_____

_____

_____ _____
Signature of Patient or Legal Guardian (date)