CHILDREN'S RESOURCE GROUP
CRG ASSOCIATES
REQUEST TO RESTRICT PHI USES OR DISCLOSURES FORM

I hereby request the following restrictions on Children's Resource Group's/ CRG Associates' uses or disclosures of my PHI *(Please check only those boxes that apply and describe the nature of the requested restriction; use extra pages if necessary; cross out any boxes that do not apply at this time):*

_____ Please do not telephone me at my home telephone number regarding upcoming appointments, test results, bills, etc. Instead, please telephone or write me at:

____

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_____ Please do not contact the following authorized individual(s) listed on my Patient Information Form regarding my health status or treatment, except in the case of an emergency:

____

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____

Patient or Personal Representative* Signature, Printed Name, Date Completed

(*) If signed by Personal Representative, state relationship to Patient: _________________

To be filled out by Privacy Officer:

Accepted _____ **Denied _____**

Notes ____

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Privacy Officer's Signature, Printed Name, Date Completed

ORIGINAL: In Patient Record Under Privacy Tab
COPY: To Patient or Personal Representative

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