

## Request to Restrict Health Information Disclosures

***Please complete and return this form to a Department of Health and Welfare office.***

Available in Spanish. We provide interpreter services at no cost. Call 2-1-1 or 1-800-926-2588 for interpretation assistance.  
Disponible en español. Proveemos servicios de intérprete sin costo alguno. Llame al 2-1-1 ó al 1-800-926-2588 para obtener la ayuda de un intérprete.

Client Name _____ <small>(First, MI, Last)</small>	Client Date of Birth _____
Client Home Address _____	
Client Mailing Address (if different) _____	
Client Telephone _____	
Requestor Name (if different than client) _____	
Requestor Telephone _____	Requestor Fax Number (optional) _____
<i>Please list where you would like us to send our response to your request.</i>	
Name _____	
Address _____	

The health information that I would like to restrict from disclosure: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The person or business I would like to restrict from receiving the information: \_\_\_\_\_

\_\_\_\_\_

Time period for which I would like this restriction on health information to be effective: \_\_\_\_\_

\_\_\_\_\_

If the Department agrees to your request, we will comply unless the information is needed to give you treatment, or until you terminate the restriction.

I understand that I may request to terminate this restriction at any time by completing and submitting the proper Department form. A Request to Terminate a Health Information Restriction form is available at Department offices.

**The Department will respond to your request in writing.**

If this request is being made by someone other than the subject of the information, please describe and provide documentation of your authority to request to restrict health information disclosures for that person \_\_\_\_\_

\_\_\_\_\_

Your signature \_\_\_\_\_ Date requested \_\_\_\_\_

**Your signature must be notarized if you submit this request by fax, mail or e-mail and we cannot verify it with information already on file.**

I, \_\_\_\_\_, being a Notary Public, do hereby certify that on this day \_\_\_\_\_ of \_\_\_\_\_, 20\_\_\_\_, the above individual, having been first duly sworn, appeared before me and signed the foregoing document.

\_\_\_\_\_  
Signature of Notary Public

\_\_\_\_\_  
Notary Public residing at \_\_\_\_\_

\_\_\_\_\_  
My commission expires on \_\_\_\_\_

**For DHW Office use only**

ID Provided \_\_\_\_\_

Form Complete \_\_\_\_\_

Authority:

Accessing own records \_\_\_\_\_

Documentation Attached \_\_\_\_\_

Not Required \_\_\_\_\_