



**RESTRICTION REQUEST FORM
FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

In completing this form, you are requesting the following restrictions be considered as limitations to the Muslim Community Center Medical Clinic (MCCMC) use and disclosure of your protected health information. If we agree to your request, we are bound by the terms of the agreement. You will be notified in writing of the MCCMC's decision to accept or deny your restriction request. Until a decision is reached, your request for restriction will not be honored.

Requested Restrictions and Reason for Request:

Print Patient Name: _____

Medical Record/Account #: _____

Patient's Signature

Date

Patient's Legal Representative

Relationship to Patient

For MCCMC use only:

In regards to the request stated above, the MCCMC: ____Accepts ____Denies	
Reason: _____	

_____ MCCMC Representative Signature	_____ Date