

**RESTRICTION AGREEMENT
RELEASE OF PATIENT PROTECTED HEALTH INFORMATION
CONSENT FORM**

Release Information to: _____

Address: _____

Reason for Release: _____

Please Initial:

_____ I hereby authorize The company to provide the above-named individual or company with all medical data and information they may request, as listed below, concerning my illness or injury.

_____ I hereby authorize The company to provide the above-named individual or company with specific elements of my medical data and information as designated below, concerning my illness or injury.

_____ I hereby refuse The company to provide the above-named individual or company with medical data and information concerning my illness or injury.

MEDICAL DATA/INFORMATION

_____ Name, address, phone number

_____ Social security number

_____ Date of admission

_____ Admitting diagnosis

_____ Findings of physical examination

_____ Clinical Laboratory data

_____ Reports of diagnostic tests

_____ Reports of surgical procedure

_____ Listing of medications

_____ Listing of treatments

_____ Information from physician consults

_____ Ancillary personnel notes (check all those that apply)

- | | | |
|-----------------------------------|---|---|
| <input type="checkbox"/> Nursing | <input type="checkbox"/> Social Service | <input type="checkbox"/> Nutritional Services |
| <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Psychiatric Services | |

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____

(original to be placed in patient's medical record)