REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION

I, _____, wish to give the following individual(s) access to communicate with CIMS about my medical information as follows: (**Please select only <u>ONE</u> option and initial**)

_____ I grant CIMS permission to communicate confidentially with the named individual(s) below.

*I understand that if I place my initials next to **<u>"No Restrictions"</u>** CIMS may discuss my appointments, my health information, and my designated individual(s) will have access to my medical records.*

*I understand that if I place my initials next to **<u>"Appt Only"</u>** that CIMS will not discuss any of my health information or provide access to my medical records. I only give CIMS permission to disclose my appointments.*

1. _____- Relationship: _____ **No Restrictions: _____ Appt Only: _____**
2. _____- Relationship: _____ **No Restrictions: _____ Appt Only: _____**
3. _____- Relationship: _____ **No Restrictions: _____ Appt Only: _____**

_____ I <u>DO NOT</u> wish to grant access to any other individual(s). Please <u>DO NOT</u> discuss my health information, give access to my records, or provide any appointment information.

TO OUR PATIENTS:

Although the law does require us to agree to your requested restrictions, if we do agree to the requested restriction, we will abide by the restriction unless a medical emergency or law requires otherwise. You also have the right to request that we communicate certain medical information to you in confidence. We will accommodate your reasonable written requests to receive communications of medical information by alternative means or at alternative locations only if you (1) specify the alternative location, address, or telephone number and/or the alternative means of contact and (2) agree to be responsible for and explain how payment will be handled for any additional costs associated with the alternative method of communication.

This signed authorization is valid until I, _____, provide CIMS with a written authorization indicating changes or revocation.

Signature of Patient: _____ Date: _____