

THE PAIN CENTER OF ARIZONA, P.C.

RESTRICTION / CONFIDENTIAL COMMUNICATIONS REQUEST

Patient Name: _____
Address: _____

Other Name: _____
Birth date: _____
Soc. Sec No.: _____
Phone (Day): _____

Information to be restricted:

Describe requested restriction:

OR

Alternative contact information for confidential communications:

Patient Personal Representative's Signature Date

Description of Representative's Authority to Act for Patient

FOR OFFICE USE ONLY: Restriction / Confidential Communications Request Review

Request Reviewed by: _____ Title: _____

Date: _____

Request: _____ Approved _____ Denied

Reviewer Comments/Actions:

THE PAIN CENTER OF ARIZONA, P.C.

DATE:

RE: Request for restrictions on disclosure or confidential communications

Dear PATIENT,

_____ Your request for additional restrictions for your protected health information has been

- Approved.
- Denied. We cannot accommodate this request.

_____ Your request for confidential communications has been

- Approved.
- Denied. Request for alternative communications is not reasonable.

Sincerely,