Amarillo Colon and Rectal Clinic
Restrictions on Privacy Rule of Patient Authorization and Consent Agreement

I,_____, (patients name), understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that I have the right to restrictions regarding the use and disclosure of my Protected Health Information.

I understand that:

- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations by other covered entities.
- I may revoke this consent in writing at any time, except to the extent that this facility has already taken action in reliance thereon. I understand that this action may limit my future treatment options.

I am requesting the following restrictions on the use and disclosure of my Protected Health Information.

Requested restriction:

_____
_____
_____
_____

Signature of Patient or Legal Representative Witness _____

Printed Name of Patient or Legal Representative Witness _____

Date: _____

Office Use Only

This facility acknowledges and agrees to your requested restriction regarding your Protected Health Information. _____.

Request for restriction regarding your Protected Health Information was denied: _____.

HIPAA Officer's Signature _____Date _____