COSHOCTON COUNTY EMS
PATIENT REQUEST FOR RESTRICTION FORM
ATTACHMENT G

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____

Patient Rights: As a patient, you have the right to request restrictions to the uses and disclosures of your PHI. **Coshocton County EMS is not required to agree to any restrictions requested by the patient, however, any restrictions agreed to by Coshocton County EMS are binding on Coshocton County EMS.**

Please indicate your request for restricted uses and disclosures of your PHI.

_____

_____

_____

_____

Signature: _____ ***Date:*** _____

FOR CCEMS USE ONLY

Date Received _____ Entered in Log _____

Request Accepted _____ Request Denied _____

Date _____ Reviewing Official _____

Notice to Patient _____