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

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Patient Name: _____

Phone #: _____

Street or P.O. Box: _____

City: _____ State: _____ Zip: _____

- 1) Medical Information to be Restricted:
- 2) Nature of Restriction:
- 3) Person(s) restricted from obtaining medical information:
- 4) Medical Information to be Communicated Confidentially:
- 5) Alternate Location/Address/Telephone #/Email:

To Our Patients: You have the right to request that we restrict our use and disclosure of your medical records and information. We do not have to agree to your requested restrictions. If we do agree to the requested restriction, we will abide by the restriction unless a medical emergency 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.

By your signature below, you acknowledge that you understand and agree to the above information.

Signature of Patient: _____ Date: _____

Request for Restriction: Accepted: _____ Denied: _____

Request to Communicate Confidentially: Accepted: _____ Denied: _____

This request for restricted and confidential communication is to be made a part of the medical record of

Patient Name: _____