REQUEST FOR RESTRICTIONS ON USES AND/OR DISCLOSURES OF MY MEDICAL RECORD

Patient Name: _____ Date of Birth: ____ /____ /_____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

I understand that I have a right to request restrictions on certain uses and/or disclosures of my medical record made by Women's Health Associates of Southern Nevada, PLLC.

I request that the use and/or disclosure of my medical record be restricted in the following manner:

_____

_____

_____

_____

I understand that WHASN may deny this request in whole or in part based upon the professional judgment of WHASN.

If this request for restrictions on certain uses and/or disclosures of my medical record is granted, in whole or in part, I understand that I may cancel this restriction at any time by notifying WHASN. I also understand that WHASN may terminate this restriction at any time after WHASN notifies me of the termination.

_____
Patient Name

_____ _____/_____/_____
Patient/Health Care Agent/Guardian/Relative Signature Date

_____
Description of Personal Representative's Authority