SABLE-ALTURA FIRE PROTECTION DISTRICT

Request for Restriction of Protected Health Information

Patient Name_____ Date:_____

Address:_____

City:_____ State:_____ ZIP Code_____

Birth Date:_____ Social Security Number_____

Your rights as a patient: As a patient, you have the right to request restrictions to the uses and disclosures of your protected health information. The Sable-Altura Fire Protection District (the "District") is not required to agree to any restrictions you may request; however, the District is bound by any restrictions to which it agrees.

Please state your request for restricted uses and disclosures of your protected health information. Please attach a separate sheet if necessary.

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Patient Signature:_____ Date:_____