DIABETES ASSOCIATES MEDICAL GROUP

Restriction of Use or Disclosure of Protected Health Information (PHI)

Form

I, _____, request that Dr. Ivy-Joan Madu's Office

restrict the use or disclosure of my

_____ to _____.

Patient Signature: _____

Date: _____

Privacy Officer Comments:

___ Accept this request.

___ Reject this request.

___ Patient contacted ___/___/_____

Amendments

Document Amended on (Date), By _____