McLaren Ambulatory Care Center,
McLaren Occupational Health and/or Convenient Care Center
REQUEST FOR RESTRICTION OF USE OR DISCLOSURE OF HEALTH INFORMATION

I, _____, request that McLAREN MEDICAL GROUP restrict the use or disclosure of my protected health information for the purposes of treatment, payment, or health care operations, or regarding a person involved with my health care, in the following manner: _____

_____

_____

Describe requested restriction: _____

_____

_____

_____

_____

_____

I understand that if I am in need of emergency treatment and the restricted information is necessary for the provision of emergency treatment that McLAREN MEDICAL MANAGEMENT, INC. may use or disclose the information to provide the emergency treatment.

Signature: _____ Date: _____ / _____ / _____

FOR OFFICE USE ONLY

Upon reviewing Patient's Request for Restriction, McLAREN MEDICAL MANAGEMENT, INC.:

❑ Agrees to Patient's Request for Restriction.

❑ Does not agree to Patient's Request for Restriction.

Signature: _____ Date: _____ / _____ / _____

Department: _____

Printed: _____