



REQUEST FOR RESTRICTION

Patient Name: (print) _____

Street/PO Box: _____

City/State/Zip: _____

Information to Restrict:

Incident No. _____

Please indicate your request for restrictions to the uses and disclosures of your protected health information.

Please allow 30 days to process this request. Tualatin Valley Fire & Rescue is not required to agree to any restrictions requested by the patient, however any restrictions agreed to are binding.

Signature of Patient or Other Person Authorized to Sign for Patient

Date

Relationship to Patient

Printed Name