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. Lake Oswego Fire Department 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 / Phone Number

_____ _____

Relationship to Patient | Printed Name

Lake Oswego Fire Department
300 'B' Avenue; P.O. Box 369 Lake Oswego, OR 97034 • Phone (503) 635-0275 • Fax (503) 635-0376 •