

# Protected Health Information RESTRICTION AGREEMENT

Release Information to: \_\_\_\_\_

Address: \_\_\_\_\_

Reason for Release: \_\_\_\_\_

**Please Initial:**

\_\_\_\_\_ I hereby authorize the Heart & Family Institute to provide the above-named individual or company with all medical data and information they may request, as listed below, concerning my illness or injury.

\_\_\_\_\_ I hereby authorize the Heart & Family Health Institute to provide the above-named individual or company with specific elements of my medical data and information as designated below, concerning my illness or injury.

\_\_\_\_\_ I hereby refuse the Heart & Family Health Institute to provide the above-named individual or company with medical data and information concerning my illness or injury.

### MEDICAL DATA/INFORMATION

\_\_\_\_\_ Name, address, phone number

\_\_\_\_\_ Social Security Number

\_\_\_\_\_ Date of treatment

\_\_\_\_\_ Diagnosis

\_\_\_\_\_ Findings of physical examination

\_\_\_\_\_ Laboratory date

\_\_\_\_\_ Reports of diagnostic tests

\_\_\_\_\_ Reports of a procedure

\_\_\_\_\_ Listing of medications

\_\_\_\_\_ Listing of treatments

\_\_\_\_\_ Information from physician consults

\_\_\_\_\_ Ancillary personnel notes (check all those that apply)

\_\_\_\_\_  Nursing  Diagnostics  Cath Lab  Nuclear Medicine  Pharmacy

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_