

NOTICE OF RESTRICTION FOR RELEASE OF PATIENT INFORMATION

I am restricting the use and disclosure of protected health information for the following patient as described in this restriction.

PATIENT NAME: _____

Date of Birth: _____ Social Security Number: _____

The following information may NOT be released by Associated Billing Services, Inc. as a business associate of _____ (Provider):

- Billing records which include statements or itemized bills, insurance claim forms, explanation of benefits, records of billing to third party payers.
- Entire medical record including history, physical and consultation notes, treatments provided, diagnosis, prescriptions, questionnaires, treatment plans, test/lab results, correspondence, photos and any other items contained in my medical record.

MAY NOT BE RELEASED TO:

Name

Healthcare Provider Facility Physician Other _____

Street Address of the above named individual or entity City State Zip Phone

EFFECTIVE: _____ TO: (date or event) _____

I understand that at any time I may revoke this restriction. To do so, a copy of the original notice of restriction will be sent back to me and I will complete the REVOCATION OF RESTRICTION SECTION below.

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

(If Personal Representative, please indicate relationship to patient: spouse, parent, *legal guardian or *power of attorney. *Please include a copy of legal documentation.)

Date

Please keep a copy of this Authorization or Revocation thereof for your records.

REVOCATION OF RESTRICTION

On this day, _____, I am revoking the above restriction for the release of the above information to the above named Healthcare Provider/Facility/Physician/Other Individual.

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Please keep a copy of this Authorization or Revocation thereof for your records.