MANSFIELD
F·A·M·I·L·Y
PRACTICE
A LIMITED LIABILITY COMPANY
34 PROFESSIONAL PARK ROAD
STORRS, CONNECTICUT 06268
TEL: (VOICE) 860/487-0002
(FAX): 860/429-1663

# Request for Restrictions on Uses and Disclosures of Protected Health Information

Patient Name _____ Date of Birth _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

I, _____, hereby request that Mansfield Family Practice, LLC restrict:

☐ Uses and disclosures of my protected health information to carry out treatment, payment or health care operations as follows (please specify):

_____

_____

_____

☐ Disclosures to family and friends involved in my care or for notification purposes as follows (please specify): _____

_____

_____

I understand that Mansfield Family Practice, LLC is not required to agree to my request for restriction and that disclosures required by law and for emergency treatment shall be made regardless of any request for restriction made by me.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Name (Please Print) Relationship to Patient