



# **DISCLOSURE RESTRICTION REQUEST FORM**

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**THIS FORM IS TO BE USED TO FILE AN OFFICIAL REQUEST FOR  
RESTRICTION OF PHI DISCLOSURE.**

## **PATIENT IDENTIFICATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

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

## **REQUEST FOR PHI DISCLOSURE RESTRICTION**

I understand I have the right to request to a restriction of how UCF Health Services uses and discloses my protected health information. I understand that UCF Health Services will make every reasonable effort to agree to the restriction(s) requested regarding my protected health information.

Pursuant to that right, I hereby request UCF Health Services to make every reasonable effort to restrict use and disclosure of my protected health information as follows: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_.

## **RIGHT OF DENIAL**

I understand that UCF Health Services has the right to deny my request for a restriction on the use and disclosure of my protected health information to the extent allowed by law. I also understand that UCF Health Services may deny my request for restriction of my protected health information if it is not in writing or does not include a reason to support the request.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

*Gina Shahbandar, Privacy Compliance Officer or Betty Calton, Patient Advocate  
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