APPENDIX II

FORM 10

REQUEST FORM, RESTRICTION ON USE OF PHI AND DISCLOSURE

CLAY COUNTY

REQUEST FORM

RESTRICTION ON USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: _____ Address: _____

Social Security Number: _____ _____

Date of Birth: _____ _____

Date: _____

This is a request for a restriction on Use and Disclosure of Personal Health Information. Explain the request and basis for the request: (attach additional sheets of paper if needed)

_____
_____
_____
_____
_____
_____

You will be notified by the Clay County ("Clay County") Privacy Officer if your request will be granted or denied. The Clay County Privacy Officer will act on your request as soon as administratively possible.

*__PLEASE NOTE__ that your request is governed by federal law and may be granted or denied as determined by the Clay County Privacy Officer in accordance with such law. The Clay County Privacy Officer will notify you of its decision in writing and will provide you with reasons for a denial.

I certify that I have completed, read, and understood this Request Form.

_____ _____

Requestor's Signature Printed Name Date

Deliver this form to the Clay County Privacy Officer