

**Kansas City Bone & Joint Clinic, P.A.**  
**Request to Restrict Disclosure of Protected Health Information**

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**Please complete the following information:**

1. Today's Date: \_\_\_\_\_
2. Patient's Full Legal Name: \_\_\_\_\_
3. Birth date \_\_\_\_\_ 4. Patient Acct# \_\_\_\_\_
5. Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
6. Please describe the health information that you want to restrict disclosure:  
(For example, statements on physical exam or test results).  
\_\_\_\_\_
7. What is the date(s) of the information you would like to restrict? As accurately as possible,  
please list the date(s) of the office visit or date of treatment related to the information you would  
like to restrict:  
\_\_\_\_\_
8. What is your reason for making this request? \_\_\_\_\_  
\_\_\_\_\_
9. Please list the person(s) or entity to which you would like these restrictions to apply:  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Patient / Legal Representative: \_\_\_\_\_

Date: \_\_\_\_\_

Individual other than Patient: \_\_\_\_\_ Relationship \_\_\_\_\_

Date: \_\_\_\_\_

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**FOR OFFICE USE ONLY**

Restriction has been:       Accepted       Denied

Signature of Privacy Officer: \_\_\_\_\_ Date: \_\_\_\_\_