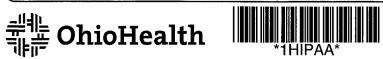
I, hereby request that th disclosures of my personal health information by	e following restriction(s) be placed on the uses and (list location).
Please give a full, specific description of the type of restrictions you are requesting regarding how and to whom your personal health information is used and disclosed. Restrictions may only be requested for those uses and disclosures that relate to your treatment, your payment, insurance, or the business operations of OhioHealth.	
Please list restrictions requested:	
I understand that OhioHealth is not required to agree to my restriction requests, but that OhioHealth is only required to attempt to accommodate reasonable requests when appropriate. Further, I understand that OhioHealth reserves the right to terminate an agreed to restriction if it feels that termination is appropriate. If I wish to terminate any agreed to restriction, I must send a written termination notice to the attention of the OhioHealth Privacy Officer, 180 East Broad Street, Columbus, Ohio 43214.	
Patient Name	Date of Birth
Medical Record Number	-
Name of personal representative (if applicable)	
Relationship of personal representative	-
Signature of patient (or patient's representative) Please send a copy to E	Date thics and Compliance





PATIENT IDENTIFICATION LABEL

PATIENT REQUEST TO RESTRICT **USES AND DISCLOSURES OF** PERSONAL HEALTH INFORMATION