# Tulsa Health Group

## Restriction / Authorization of Use or Disclosure of Protected Health Information (PHI) Form

I, ________________________(legal name), request that Tulsa Health Group restrict / authorize (circle one) the use or disclosure of my health information for treatment, payment or health care operations in the manner described here: (Full name and relationship)

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

I understand that Tulsa Health Group is not required by law to accept my requested restrictions, but if the practice does, Tulsa Health Group agrees to abide by the restrictions except in emergency situations.

I understand that either I or Tulsa Health Group may terminate this restriction in writing at any time in the future.

Patient Signature: ____________________________________________

Date of birth:__________________________________

Date: ______________________________________________________

**Privacy Officer Comments:**

___ Accept this request.

___ Reject this request. Reason:_______________________________________

___ Patient contacted.