Davis Behavioral Health

Client Restriction on the Uses and Disclosures of PHI for Treatment, Payment or Operations

Client Name:_____

Client Number: _____

Social Security Number:_____

Address:_____

_____

Telephone Number:_____

Restriction

requested:_____

_____

_____

This restriction reviewed with client:

Date:_____

By:_____

(Name and Position of Individual Reviewing Restriction with Client)

Face to Face:_____ Phone call: _____

Restriction Approved: Yes ☐

No ☐

Date: _____

Signature of employee approving/denying restriction: _____

Name of employee approving/denying restriction: _____

Signature of Client (required):_____

Signature of Privacy Officer:_____ Date:_____