

**Jefferson Rural Fire Protection District
Patient Request for Restriction Form
Form 100.15.F6**

Patient Name _____ Date ___ / ___ / ___

Address _____

City _____ State _____ Zip Code _____

Social Security No.: ___ / ___ / _____

Patient Rights: As a patient, you have the right to access, copy or inspect your PHI, amend your PHI, request an accounting of the uses and disclosures of PHI for the last six (6) years, prior to the date of your request, from Jefferson Fire District Ambulance, to amend your PHI and to request restrictions to the use and disclosure of your PHI.

Jefferson Fire District Ambulance is not required to agree to any restrictions requested by the patient, however any restrictions agreed to by Jefferson Fire District Ambulance are binding on Jefferson Fire District Ambulance.

Please indicate your request for restrictions uses and disclosures of your PHI.

Signature _____ Date ___ / ___ / ___