

**Scotland County EMS  
Patient Request for Restriction Form**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Social Security No.: \_\_\_\_\_

*Patient Rights:* As a patient, you have the right to request restrictions to the uses and disclosures of your PHI. **Scotland County EMS is not required to agree to any restrictions requested by the patient, however any restrictions agreed to by Scotland County EMS are binding on Scotland County EMS.**

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

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Signature \_\_\_\_\_ Date \_\_\_\_\_

**FOR AMBULANCE SERVICE USE ONLY**

DATE REC'D \_\_\_\_\_

REQUEST ACCEPTED \_\_\_\_\_

REQUEST DENIED \_\_\_\_\_

DATE \_\_\_\_\_

REVIEWING OFFICIAL \_\_\_\_\_

NOTICE TO PT \_\_\_\_\_

COMMENTS:

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