**Response to Request for Restrictions of Use and Disclosure of PHI**

**(Name of Practice)**

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

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Street City, State Zip

Date of Patient Request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We have reviewed your request for restrictions on the use and disclosure of PHI on \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_.

(*See attached copy of the original request)*.

 Your request has been accepted.

We will make the necessary assurances to accommodate your request.

 We regret to inform you that your request has been denied for the following reasons:

If you do not agree with our denial you may submit a complaint to the Secretary of Health and Human Services and/or a complaint to our clinic at the following address:

Attention: <Name of Compliance Officer>

Street Address

City, State, Zip Code

Sincerely,

Privacy Officer