Request for Restriction of Use and Disclosure Form

Use this form to request or terminate a restriction of our use and disclosure of your protected health information (PHI).

Please complete the following:

Name: ____

Date of Birth: ____

Address: ____

Telephone #:_________________________________Cell Phone #: ______________________________

E-Mail Address: ____

I request Kootenai Health to restrict the use or disclosure of my PHI as specified below:

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Signature:____________________________________Date: ___________________________________

Patient/Legal Representative:____Date: __________________

If you need assistance completing this form, please call the HIM Department (208) 625-6222.

The form must be completed entirely. When complete send to:

Kootenai Health
Health Information Department
2003 Kootenai Health Way.
Coeur d'Alene, ID 83814