
DANVILLE FIRE DEPARTMENT

PATIENT REQUEST FOR RESTRICTION

Danville Fire Department and Center Township / Danville

Ambulance Service

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. **Danville Fire Department and Center Township / Danville Ambulance Service is not required to agree to any restrictions requested by the patient, however any restrictions agreed to by Danville Fire Department and Center Township / Danville Ambulance Service are binding on Danville Fire Department and Center Township / Danville Ambulance Service.**

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

Signature _____ *Date* _____

FOR AMBULANCE SERVICE USE ONLY:

DATE RECIEVED _____

REQUEST ACCEPTED _____

REQUEST DENIED _____

DATE _____

REVIEWING OFFICIAL _____

NOTICE TO PT _____

COMMENTS: _____
