

Request for Restrictions and Sharing of Information with Persons Other Than The Patient

I, _____, request the following
 (Patient Name)
 restrictions to the use or disclosure of my protected health information.

Dayton Surgeons Inc. may discuss my medical condition / information with the following:

	YES	NO	NA	
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please list names of all children that we may speak with. We will not speak with those who are not listed.
Friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Please specifically list the name of friends that we may talk with concerning your protected health information.

Name of Person

Relationship

Signature of Patient

Date