



NEW ENGLAND
ORTHOPEDIC SURGEONS

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(413) 785-4666 • www.neortho.com

HIPAA Request for Restrictions to Uses and Disclosures

Patient Name: _____ Date of Birth: _____

Patient Acct. # _____

We will consider your request based upon our practice's ability to:

1. Carry out your request;
2. Continue to provide appropriate treatment; and
3. Comply with applicable claim submission requirements.

Our Office's privacy official as well as your physician will review your request and we are available to discuss any of your issues or concerns related to your request.

What type of information do you request to be restricted or limited?

How would you like your information restricted?

Signature: _____

Date: _____

Privacy Official Use: