TRINITY
HAND SPECIALISTS

2335 Knob Creek Rd, Ste 100 | Johnson City, TN 37604
PO Box 5969 | Johnson City, TN 37602

Phone | 423-282-5332
Fax | 423-722-1682

trinityhand.com

REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATIONS

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Phone: _____
Street or PO Box

_____
City State Zip

Who are you allowing Trinity Hand Specialists to disclose confidential information to: _____

_____

Medical information to be communicated confidentially: _____

_____

Medical information to be restricted: _____

_____

Nature of restriction: _____

Alternative Location/Address/Telephone Number/Fax Number: _____

_____

TO OUR PATIENTS: You have the right to request restriction on the use and disclosure of your information. If you request such a restriction, we may choose to either comply with your request or terminate your care here. In certain instances, your choice to restrict the disclosure of information may invalidate your insurance coverage, and we may require that you execute both a waiver of insurance benefits and a payment agreement in order to receive care. If you have been inured on the job and have filed a workers' compensation claim, Tennessee law forbids limiting disclosures to your carrier or self-insured employer.

Generally, we will not agree tor requests to limit disclosure of your information related to (a) coordination of your medical care, (b) the internal operations of our practice, or (c) legal requirements. It is simply too difficult to comply with such restrictions.

You have the right to request that we communicate certain medical information to you or someone you have allowed to receive your information in confidence. We will accommodate your reasonable written requests to receive communications of medical information by alternative means, at alternative locations and/or to allow someone you have designated to receive confidential information only if you (1) specify the person you have allowed access to your confidential information, and (2) specify the alternative location, address, telephone number or fax number and/or the alternative means of contact.

By your signature below, you acknowledge that you understand and agree to the above information.

_____ _____
Patient Signature Date

- Below this line for **TRINITY HAND SPECIALISTS** use only - - - - - - - - - - - - - - - - - -

___ Request for restriction accepted
___ Request for restriction denied
___ Request to communicate confidentially accepted
___ Request to communicate confidentially denied

_____ _____
Signature of Trinity Hand Specialists Staff Date