LifeCare Ambulance Medical Services
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 access, copy or inspect your PHI, amend your PHI, request an accounting of the uses and disclosures of PHI for the last six (6) years, prior to the date of the request, from LCA, to amend your PHI and to request restrictions to the uses and disclosures of your PHI. LCA is not required to agree to any restrictions requested by the patient, however any restrictions agreed to by LCA are binding on LCA.

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

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Signature ____ Date ______________