ONCOLOGY ASSOCIATES OF SAN DIEGO

A MEDICAL GROUP

Dr. Robert M. Barone, M.D., F.A.C.S. Dr. Paul M. Goldfarb, M.D., F.A.C.S.

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

Patients Name:_____

Phone Number {Day}:_____

Phone Number {Evening}:_____

Street or PO Box:_____

City:_____

State:_____

ZIP: _____

1) Medical Information Restricted:

2) Nature of Restriction:

3) Medical Information to be Communicated Confidentially:

4) Medical Information to be Communicated Confidentially:

TO OUR PATIENTS: You have the right to request that we restrict our use and disclosure of your medical records and information. We do not have to agree to your requested restrictions. If we do agree t the requested restriction, we will abide by the restrictions. If we do agree to the requested restriction, we will abide by the restriction unless a medical emergency requires otherwise. You also have the right to request that we communicate certain medical information to you in confidence. We will accommodate your reasonable written requests to receive communications of medical information by alternative means or at alternative locations only if you (1) specify the alternative location, address or telephone number and/or the alternative means of contact and (2) agree to be responsible for and explain how payment will be handled for any additional costs associated with the alternative method of communication.

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

Signature of Patient:_____

Request for Restriction Accepted:_____

Request for Restriction Denied:_____

Request to Communicate Confidentially Restriction Accepted:_____

Request to Communicate Confidentially Restriction Accepted Denied:_____

This Request for Restriction and Confidential Communication Form is to be made part of the medical record of: (Patient Name) _____