

Restriction Request Form

For Use and Disclosure of Protected Health Information (PHI)

In completing this form, you are requesting the following restrictions be considered as limitation to UTD/Callier Center uses and disclosure of your PHI. If we grant your request, we are bound by the terms of the agreement. You will be notified in writing of UTD/Callier Center's decision to accept or deny your restriction request. Until a decision is reached, your request for restriction will not be honored.

Requested Restrictions: (Please provide specific details and date)

Print Patient Name: _____

Signature of Patient or Surrogate Decision Maker: _____

Relationship to Patient: _____ **Date:** _____

For CCCD Use Only:

CCCD: Accepts Denies

CCCD Signature: _____ Date: _____

Notice:

**Route this form to Medical Records Department after
The individual has completed the form:
UTD/Callier Center for Communication Disorders
Medical Records
1966 Inwood Rd.
Dallas, TX 75235**