NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

**REQUEST TO RESTRICT THE USE OF
CONFIDENTIAL INFORMATION**

PATIENT'S LAST NAME	FIRST	M.I.
CASE NO.		
FACILITY	UNIT	

INSTRUCTIONS: **GIVE A COPY OF THE FORM TO THE PATIENT!** Prepare one (1) copy for the Patient's Case Record.

REQUEST FOR RESTRICTION OF INTERNAL USE OF INFORMATION

RESTRICTION REQUESTED

WHICH INFORMATION:

INDIVIDUAL(S) INFORMATION SHOULD BE RESTRICTED:

REASON FOR RESTRICTION

I, the undersigned, hereby request that the use of my medical information/record be restricted as described above. I understand that the facility may deny my request with cause.

_____   _____
(Signature of Patient)   (Signature of Parent/Guardian, when required)

_____   _____
(Print Name of Patient)   (Print Name of Parent/Guardian)

_____   _____
(Date)   (Date)

Facility Action:

___Request approved.

___Request Denied. Reason for Denial
     ___ Use of the information is vital to the provision of treatment of the patient.

     ___Other reason. Describe _____

_____
Director/Assistant Director   DATE

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