Request to Additional Restrictions

Please complete the information below to request Additional Restrictions. The Facility will review your request and notify you as to whether your Additional Restrictions have been accepted.

Patient Name	Date of Birth
Address	Telephone #

Describe the Additional Restrictions you would like placed on the uses and disclosures of your Protected Health Information.

Patient/Personal Representative Signature	Date
Printed Name if Not the Patient	Relationship

Sign below only if your are terminating previously accepted Additional Restrictions	
Patient/Personal Representative Signature	Date
Printed Name if Not the Patient	Relationship

When completed, please return to Hopkins Center Drug
Or Mail to:
Hopkins Center Drug
913 Hopkins Center
Hopkins, MN 55343

Internal Use Only	
Received and Reviewed by (Print)	Date
Restrictions have been ☐ Approved ☐ Denied (explain reason for denial) Patient/Personal Representative Notified of Denial and Reason? ☐ Yes ☐ No	
Date the Additional Restrictions are Terminated:	