REQUESTED RESTRICTION ON USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FORM

I, _________________________________, **do / do not** give Dr Beverly A Carl permission to leave general information on an answering machine. I understand that this may pertain to medical information.

I also give her permission to speak with:

Name ____________________________relationship_____________

Name ____________________________relationship_____________

Name ____________________________relationship_____________

List any restrictions with whom we may speak:

Name ____________________________relationship_____________

Name ____________________________relationship_____________

Signature________________________________Date_____________

You may revoke this authorization at any time by submitting your request to Olivia Feit @ 500 Market Street Suite 202 W Bridgewater, Pa 15009 or 724-728-8840