Confederated Tribes of Siletz Indians
Siletz Community Health Clinic
Post Office Box 320 • 200 Gwee-Shut RD
Siletz, OR 97380
Telephone: 800-648-0449 • (541)444-1030
Facsimile: (541)444-9695

REQUEST FOR RESTRICTION(S)

I understand I have the right to request restriction(s) as to the use and/or disclosure of my Protected Health Information (PHI) to carry out treatment, payment, health care operations, or disclosures to family members and others involved in my care. I understand SCHC may disagree to the restriction(s) requested. I understand if SCHC denies my request, I will have the opportunity to agree or object prior to disclosures to persons involved in my care. If SCHC agrees to my request for restriction(s) it will be binding except in the case of emergency treatment then I understand restricted information may be released. SCHC will request the Provider to no longer use and/or disclose that information. Complete and return this form to the above address to the attention HEALTH INFORMATION.

I request the following restriction(s) on the use and/or disclosure of my PHI:

Print name, sign and date. If your signature is your mark or thumbprint then your Representative or Witness will need to sign and state their relationship to you.

Print Patient's Name (First, Middle Initial and Last)	Date Signed
Signature of Patient	Mark or Thumb Print

Signature of Personal Representative or Witness	Relationship

	If accepted, state which of the restriction(s) accepted:
☐Accepted ☐ Denied	

Signature of SCHC Administrator or Designee	*Date Signed*

SCHC HEALTH INFORMATION USE ONLY:

NAME (Last, First, MI)	MRN	DOB	Scanned