Restore Medical Fitness
4545 Transit Rd.
Williamsville, NY 14221
716-906-2102

HIPAA Compliance Office
Maria Kreher

F-1004 HIPAA – Restricted Use and Disclosure Request

PATIENT INFORMATION

Date

Name (Last, First, Middle initial) | Date of Birth

Street address, City, ST, ZIP Code | Email address

Primary phone number | Other phone number | Fax number

Disclosure change affects: (Select all that apply)

☐ Individual ☐ Provider ☐ Entity

List the entity/entities included in this disclosure request.

Please describe the restriction of use or disclosure requested **in detail**.

Please list Restore Medical Fitness staff member that was contacted regarding this matter:

Name of Restore Medical Fitness staff member | Date

Patient (or legal health representative) Signature | Date

(Attach additional documentation, if applicable.)

For Administrative Use Only:

Date received

Action taken

Date

Action taken

Date

HIPAA Compliance Officer Signature

Date