

**PROGRESSIVE MEDICAL, INC.
REQUEST TO RESTRICT USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

You have the right to request Progressive Medical, Inc. to restrict the use and disclosure of your protected health information to carry out treatment, payment, or operations. You also have the right to request PMI not to disclose protected health information to a family member, relative, or friend involved with your care or payment for your health care. PMI may not be able to agree with your request.

Patient Name:		Social Security No. or Claim No.	
Date of Birth:		Date of Injury:	
Street Address:			
City:		State:	Zip:
Telephone:			

CHECK ALL THAT APPLY

I request that PMI restrict use and disclosure of my protected health information in carrying out treatment, payment, or health care operations as follows: (describe)

I request that PMI restrict the use and disclosure of my protected health information to the following persons: (list names of family members, friends, etc.)

I understand that PMI may not agree to the requested restriction(s), but will notify me of its response to my request.

NOTE TO AUTHORIZED REPRESENTATIVES: If an Authorized Representative is signing this form on behalf of the patient, additional documentation supporting the authorization to disclose patient information, such as a Power of Attorney for healthcare, must be submitted in order for records to be provided.

Name of Patient (print):			
Signature of Patient or Authorized Representative:			Date:
Relationship of Personal Representative to Patient or Statement of Authority: (if applicable)			

SUBMIT THIS FORM TO ADDRESS BELOW, OR FAX TO 614-212-8008
 Progressive Medical, Inc. Attn: Medical Records
 250 Progressive Way
 Westerville, OH 43082

Fax: (614) 212-8008