RESTRICTED REQUEST FORM

Raynon A. Andrews, M.D., P.C.

I _________________________ patient of Raynon A. Andrews, M.D., P.C. request that the following restrictions be placed upon how my protected healthcare information may be used or disclosed by Raynon A. Andrews, M.D., P.C:

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Patient Name: Date of Birth:

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Patient Signature: Today's Date:

FOR OFFICE USE ONLY

Restriction accepted by Raynon A. Andrews, M.D., P.C. ☐ Yes ☐ No

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Signature of Appointed Designee: Today's Date