

**PATIENT NOTICE**  
**PRIVACY AND CONSENT FOR PROTECTED HEALTH INFORMATION**

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Date: \_\_\_\_\_

Facility Name: \_\_\_\_\_ (Name of physician, hospital or facility)

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Dear \_\_\_\_\_: (Contact person if known)

This letter asserts the right of consent as required in common law and the laws of this state. This right is based on traditional, medical ethics and principles expressed in the American Medical Association's Code of Medical Ethics.

I hereby request, to the extent allowed by law, you do not share or use any health records or sensitive information without express written permission for the following patient:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Last Four of SS#: \_\_\_\_\_

Additionally, please

- Remove patient from all marketing. This includes marketing allowed by HIPAA such as communications related to treatment, case management or care coordination.
- Remove patient from all research related disclosures.
- Contact me if you receive a subpoena requesting patient's health records, so I may review the records selected before sharing them to the extent allowed by law.
- Place copies of this consent restriction notice in patient's medical and billing records.
- Provide a copy of this consent restriction notice to your business associates

My relationship to the patient is \_\_\_\_\_. (Only if patient and requestor are different)

If you have any questions or need more information, please contact me at the address below.

Sincerely yours,

\_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_