

**Maxim Mobility, LLC**  
**REQUEST FOR RESTRICTION ON USE & DISCLOSURE OF**  
**MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION**

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

Phone Number (Day): \_\_\_\_\_

Phone Number (Evening): \_\_\_\_\_

Street or P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

- 1) Medical Information to be Restricted:
  
- 2) Nature of Restriction:
  
- 3) Medical Information to be Communicated Confidentially:
  
- 4) Alternative Location/Address/Telephone Number/E-mail:

TO OUR PATIENTS: You have the right to request that we restrict our use and disclosure of your medical records and information. We do not have to agree to your request restrictions. If we do agree to the request restriction, we will abide by the restriction unless a medical emergency requires otherwise. You also have the right to request that we communicate certain medical information to you in confidence. We will accommodate your reasonable written requests to receive communications of medical information by alternative means or at alternative locations only if you (1) specify the alternative location, address, or telephone number and/or the alternative means of contact and (2) agree to be responsible for and explain how payment will be handled for any additional costs associated with the alternative method of communication.

By your signature below, you acknowledge that you understand and agree to the above information.

Signature of Patient \_\_\_\_\_

Date \_\_\_\_\_

Request for Restriction Accepted \_\_\_\_\_

Request for Restriction Denied \_\_\_\_\_