

**INDIVIDUAL REQUEST FOR  
RESTRICTION OF INFORMATION**

Name: (First/Middle/Last) \_\_\_\_\_

Address: (Street/City/State/Zipcode) \_\_\_\_\_

Date of Birth: (Month/Day/Year) \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Request: \_\_\_\_\_

I REQUEST THAT THE FOLLOWING INFORMATION BE RESTRICTED:

- Mental Health Records
- Medical Records
- Billing Records
- Other \_\_\_\_\_

I REQUEST THE ABOVE INFORMATION BE RESTRICTED FROM THE FOLLOWING PERSON OR ENTITY:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Individual Date

IN THE EVENT THIS REQUEST IS MADE BY THE INDIVIDUAL'S PERSONAL REPRESENTATIVE

\_\_\_\_\_  
Signature of Personal Representative Date

\_\_\_\_\_  
Legal Authority of the Personal Representative