**MOSAIC LIFE CARE**

**REQUEST FOR RESTRICTION**

**Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I am requesting that you restrict the uses and disclosures of the following information:**

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**I understand that you do not have to agree to a restriction. I understand that if Mosaic Life Care agrees to a restriction, Mosaic Life Care may still use and disclose my information for:**

* **Emergency treatment**
* **When I request to access my information**
* **When I request an accounting of disclosures**
* **For facility directories, and**
* **For uses/disclosures for which consent, authorization or an opportunity to agree or object is not required.**

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**Patient/Personal Representative Date**

**If Personal Representative, Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**