

**Lake-Sumter Emergency Medical Services
Patient Request for Restriction Form**

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security No.: _____

Patient Rights: As a patient, you have the right to access, copy or inspect your PHI, amend your PHI, request an accounting of the uses and disclosures of PHI for the last six (6) years, prior to the date of the request, from LSEMS, to amend your PHI and to request restrictions to the uses and disclosures of your PHI. **LSEMS is not required to agree to any restrictions requested by the patient, however any restrictions agreed to by LSEMS are binding on LSEMS.**

Please indicate your request for restricted uses and disclosures of your PHI.

Signature _____ Date _____