



# Request for Special Privacy Protections

Ventura Orthopedics Medical Group, Inc.  
www.venturaortho.com  
Administrator | 805-641-6415

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to request that we restrict our uses and disclosures of your protected health information with respect to treatment, payment and health care operations. You also have a right to request that we restrict our uses and disclosures of your health information with respect to disclosures to members of your family and other relatives or close personal friends or other person you identify who are involved in your care or payment for your care, or to notify or assist in notifying those individuals of your location, general condition or death. This medical practice does not have to agree to your request, but if we do, we will abide by our agreement until either of us terminates the agreement.

I hereby request special privacy protection for \_\_\_\_\_  
Print Patient's Name Patient's Date of Birth

You **MAY** speak/disclose my Health Information to:

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

Phone: \_\_\_\_\_

Relationship:  Spouse  Child  
 Other \_\_\_\_\_

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

Phone: \_\_\_\_\_

Relationship:  Spouse  Child  
 Other \_\_\_\_\_

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

Phone: \_\_\_\_\_

Relationship:  Spouse  Child  
 Other \_\_\_\_\_

You **MAY NOT** speak/disclose my Health Information to:

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

Phone: \_\_\_\_\_

Relationship:  Spouse  Child  
 Other \_\_\_\_\_

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

Phone: \_\_\_\_\_

Relationship:  Spouse  Child  
 Other \_\_\_\_\_

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

Phone: \_\_\_\_\_

Relationship:  Spouse  Child  
 Other \_\_\_\_\_

**This is a complete list of all restrictions requested. All previous restriction requests are obsolete.**

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

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

If not signed by the patient (or plan member), please indicate your relationship:

- Parent or guardian of minor patient  Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient  Other (specify) \_\_\_\_\_

**NOTE: By law, this restriction will not apply with respect to information necessary to provide emergency treatment, for uses or disclosures required by law, or for certain public health activities, judicial and administrative proceedings, law enforcement purposes, coroner investigations, organ or tissue donations, research activities, specialized government functions or workers' compensation activities.**