# CITY OF FAIRBANKS FIRE DEPARTMENT

## 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 request restrictions to the uses and disclosures of your protected health information.

***The City of Fairbanks Fire Department is not required to agree to any restrictions requested by the patient, however any restrictions agreed to by City of Fairbanks Fire Department are binding on the City of Fairbanks.***

Please indicate your request for restricted uses and disclosures of your protected health information.

_____

_____

_____

***Signature*** ***Date***

**FOR AMBULANCE SERVICE USE ONLY**

**DATE REC'D** _____

**REQUEST ACCEPTED** ☐

**REQUEST DENIED** ☐

**DATE** _____

**REVIEWING OFFICIAL** _____

**NOTICE TO PT** _____

**COMMENTS:**

_____

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