ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

By signing below, you acknowledge that you have received **Woodrome Medical PA** ***Notice of Privacy Practices*** or to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

PRINTED NAMES & PHONE NUMBERS of people that confidential information can be released to:

Printed Name:_____Phone #:_____

Printed Name:_____Phone #:_____

Printed Name:_____Phone #:_____

Printed Name:_____Phone #:_____

Printed Name:_____Phone #:_____

Printed Name:_____Phone #:_____

Printed Name:_____Phone #:_____

Printed:
Patient Name:_____ Date of Birth:_____

CIRCLE ONE:
Patient or Legal Representative

_____
Signature

_____ Date:_____
Printed Name

If Legal Representative, relationship to Patient:_____