# Request to Restrict Use or Disclosure of Protected Health Information

Date of request: _____

Client Name: _____ Date of Birth: _____

Phone #: _____ ☐ Cell ☐ Home ☐ Work Ok to leave Message? ☐ Yes ☐ No

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I request that LifeStance Health (LifeStance) restrict the use or disclosure of health information as described below.

I understand that LifeStance is not required to agree to my request. Even if LifeStance does agree, LifeStance may use or disclose information to get emergency treatment for me or when required by law.

I understand that if my request involves issues about payment for my health care, LifeStance will need to know how payment for services will be made before it will agree to my request.

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I would like use and disclosure of the following health information to be restricted:_____

_____

I want this information restricted because: _____

_____

I do not want this information given to the following persons or organizations: _____

_____

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If Parent/Guardian, print name: _____ ☐ Parent ☐ Guardian ☐ Other

Signature of Client or Parent/Guardian: _____ Date: _____

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To Be Completed by LifeStance's Compliance Manager:

- ❑ Request is granted. Should LifeStance need to end these restrictions, you will be notified
- ❑ Request is denied for the following reasons(s): _____

_____

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Date of Determination: _____ Compliance Manager Signature: _____