



**REQUEST FOR RESTRICTION ON USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION
(PHI)**

In completing this form, you are requesting the following restrictions be considered as limitations to The Gift of Life Foundation's ("GOL") use and disclosure of your PHI. If we grant your request, we will take reasonable measures to comply with your direction. You will be notified in writing of GOL's decision to accept or deny your restriction request. Until a decision is reached, your request for restriction **cannot** be honored.

Requested Restrictions: _____
(Please provide specific details and dates) _____

Print Patient Name: _____

Social Security No.: _____ Birth Date: _____

Signature of Patient or
Authorized Representative: _____

Date: _____

Relationship to Patient: _____

GOL USE ONLY

GOL: _____ Accepts _____ Denies

Authorized Signature: _____ Date: _____

The Gift of Life Foundation
1348 Carmichael Way
Montgomery, Alabama 36106
Phone: (334) 272-1820
Contact: Privacy Officer