Request for Restriction and/or Confidential Communications

The undersigned individual or individual's personal representative hereby requests:

☐ Restriction of use and disclosure of protected health information;

☐ Removal of restriction of use and disclosure of protected health information; or

☐ Confidential communications

Individual Name ____

Social Security Number _________________________________ Date of Birth __________________________

Address ____

City/State/Zip____

Telephone _________________________________ Fax Number ____________________________________
(include area code) *(include area code)*

Effective Date ____

RESTRICTION/REMOVAL OF RESTRICTION
Matria is not required to agree to requests for restrictions, however, we will consider all reasonable requests.

Describe the request for a restriction or for removal of a restriction:
____

Name of Individual or
Personal Representative *(PLEASE PRINT)* ____

Signature of Individual or
Personal Representative ____ Date ___________________
(If Personal Representative, include a description of authority to act for individual)

Signature of Witness ____ Date ___________________

CONFIDENTIAL COMMUNICATIONS

Alternate Address ____

Alternate City/State/Zip ____

Alternate Telephone Number ____

Name of Individual or
Personal Representative *(PLEASE PRINT)* ____

Signature of Individual or
Personal Representative ____ Date ___________________
(If Personal Representative, include a description of authority to act for individual)

Signature of Witness ____ Date ___________________

Please submit this form directly to:
Privacy Officer
Matria Healthcare, Inc.
1850 Parkway Place Suite 1200
Marietta, GA 30067
Fax Number: 770-767-4588
If you have any questions, please contact the Privacy Officer directly at 770-767-8191

For Matria Use Only: Date that this request was received by Matria ________________________
Request Disposition ______ Approved ______ Denied