DARRELL CORBEN, M.D.
441 DEGUIGNE DRIVE, SUITE 1
SUNNYVALE, CA 94085

As required by the Health information Portability and accountability act of 1996, you have a right to request that we restrict our uses and disclosures of your protected health information with respect to treatment, payment, and health care operations. You also have a right to request that we restrict our uses and disclosures of your health information with respect to disclosures to immediate members of your family, other relatives, or other personal friends, or other person you identify who is involved in your care, or payment for your care, or to assist in notifying those individuals of your location, general condition or death. This medical practice does not have to agree to your request, but if we do, we will abide by our agreement until either of us terminates this agreement.

I hereby request special privacy protection for: _____

_____

(please print patient's name and address)

☐ I do not want my health information to be disclosed to any of the following people:

Name	Address

☐ I do not want my health information used or disclosed for any of the following purposes:

_____

_____

This request replaces and terminates any prior request for special privacy protection that I may have made.

Signed: _____ Date: _____

Print Name: _____ Telephone: _(_____)_____

If not signed by the patient, please indicate relationship:

☐ Guardian or conservator of an incompetent patient.
☐ Beneficiary or personal representative of deceased patient.

Name of patient: _____

Note: By law this restriction will not apply with respect to information necessary to provide emergency treatment, for uses or disclosures required by law, or for certain public health activities, judicial and administrative proceedings, law enforcement purposes, coroner investigations, organ or tissue donations, research activities, specialized government functions, or worker's compensation activities.