ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

REQUEST FOR RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)

INDIVIDUAL INFORMATION

Name *(Last, First, M.I.)*: _____ Assist Number: _____

Birth Date: _____ Request Date: _____

Address *(No., Street)*: _____

City: _____ State: _____ ZIP Code: _____

If you are asking to limit the use and disclosure of your Protected Health Information (PHI), please consider the following:

- The Division of Developmental Disabilities (DDD) will consider your request, they do not have to agree to your request.
- If you request to have your PHI restricted, it may delay eligibility for services you apply for through other agencies or limit services a DDD contractor may provide.

Specify the information to be restricted:

Explain why you do not want the information disclosed:

INDICATE THE ENTITY, INDIVIDUAL, CARE PROVIDER, OR ANY PERSONAL REPRESENTATIVE TO WHOM ACCESS SHOULD BE DENIED.

Individual's Name *(Last, First, M.I.)*: _____ Relationship: _____

Signature: _____ Date: _____

DDD USE ONLY

Date Received: _____

Employee's Name *(Last, First, M.I.)*: _____ Division: _____

Signature: _____ Date: _____

DDD PRIVACY OFFICER DETERMINATION:

☐ Restriction is accepted

☐ Restriction is denied

Reason for Denial:

DDD Division Privacy Officer *(Print)*: _____ Date: _____