(PLACE PATIENT ID LABEL HERE)

(ALL ENTRIES MUST HAVE DATE & TIME)

PRRF

EINSTEIN HEALTHCARE NETWORK

PATIENT REQUEST FOR RESTRICTIONS

Patient's Name: _____ Med. Rec. No.: _____

Home Address: _____

Phone: ( ) _____ - _____ Date of Birth: _____

I hereby ask Einstein Healthcare Network to accommodate the following request(s). Because I may have different records in different parts of Einstein Healthcare Network, I understand that I must make this request at each facility where I receive services.

For this Einstein Healthcare Network facility (*check **one facility** only*):

☐ EMCP ☐ EMCM ☐ EMCEP ☐ Einstein Center One ☐ GCHS ☐ MossRehab ☐ Willowcrest

☐ Einstein Physicians Philadelphia ☐ Einstein Physicians Montgomery ☐ Other: _____

I ***am requesting:*** (*check each request below*)

☐ Please do not send appointment reminders to me.

☐ Please do not provide health information about me to the following individuals:

_____

_____

☐ Please use the following address for all correspondence addressed to me:

_____

_____

_____

☐ Please use the following telephone number to leave messages for me: ( ) _____ – _____

☐ Please use the following email address: _____

☐ Please leave detailed messages for me on my answering machine or voicemail: ( ) _____ – _____

☐ Please do not leave messages for me on my answering machine or voicemail.

☐ Leave messages on MyEinstein patient portal only.

☐ Other – please describe: _____

_____

_____ _____ _____

Signature of Patient (or Legal Representative) Date Time (military)

_____ _____ _____

Printed Name of Legal Representative Date Time (military)

_____

Relationship to Patient

For Internal Use Only **The Patient's Request(s):**

☐ Will be accommodated at the facility checked above.

☐ Cannot be administratively accommodated at the facility checked above.

☐ Other: _____