Harmony Acupuncture, LLC
Virginia Beach, VA

Restriction Request Form

I understand that my health information is private and that use of my health information must be consistent with the Harmony Acupuncture, LLC's Notice of Privacy Practices. I also understand that I am entitled to request restrictions on certain uses and disclosures of my personal and/or health information. I wish to make the following request(s), and understand that each request may be approved or denied by a Clinic Administrator.

Print Name:_____ DOB:_____ Today's Date:_____

I am being seen by:_____.

1) **Restriction Request:**_____

_____

Client/Patient Signature:_____

□ Restriction implemented
□ Restriction denied – Reason for Denial:_____

_____

Staff Signature:_____ Date:_____

2) **Restriction Request:**_____

_____

Client/Patient Signature:_____

□ Restriction implemented
□ Restriction denied – Reason for Denial:_____

_____

Staff Signature:_____ Date:_____