Restore Medical Fitness
4545 Transit Rd.
Williamsville, NY 14221
716-906-2102

HIPAA Compliance Office
Maria Kreher

F-1003 HIPAA – Restricted Communication Request

PATIENT INFORMATION

Date

Name (Last, First, Middle initial) | Date of Birth

Street address, City, ST, ZIP Code | Email address

Primary phone number | Other phone number | Fax number

Communication change affects: (Select all that apply)

- ☐ Mailing Address
- ☐ Email
- ☐ Primary Phone
- ☐ Voicemail
- ☐ Other Phone
- ☐ Other (Specify below)

Please describe the restriction/accommodation requested **in detail**.

Alternative means of contact (Only if applicable to request)

Name (Last, First, Middle initial)

Street address, City, ST, ZIP Code | Email address

Primary phone number | Other phone number | Fax number

Please list Restore Medical Fitness staff member that was contacted regarding this matter:

Name of Restore Medical Fitness staff member | Date

Patient (or legal health representative) Signature | Date

(Attach additional documentation, if applicable.)

For Administrative Use Only:

Date received

Action taken

Date

Action taken

Date

HIPAA Compliance Officer Signature

Date