



**Elmhurst Memorial Hospital**  
 200 Berteau Ave • Elmhurst, Illinois 60126 • 630-833-1400



**ELMHURST MEMORIAL HOSPITAL  
 ELMHURST CLINIC**

**REQUEST RESTRICTIONS AND/OR REQUEST CONFIDENTIAL  
 COMMUNICATIONS FORM**

PATIENT NAME: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

MEDICAL RECORD NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: (Home) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (Office) (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Your request should specify what information you want to restrict, whether you want to restrict , use or disclosure or both, and to whom you want the restrictions to apply. If you are requesting that we communicate with you about your protected health information (PHI) in a certain way or at a certain location, you should indicate how or where you could be contacted. We will try to accommodate all reasonable requests.

Please identify below your request:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient or Patient Representative Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**HEALTH CARE PROVIDER RESPONSE**

- Request has been granted and the following areas have been notified:
  - Clinical Information Request routed to Medical Records
  - Financial Information Request routed to Patient Business Services
- Request has been denied and patient has been informed

Health Care Provider/Employee Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_