Dr. David R. Winchester, D.M.D., P.C.
Request Additional Restrictions on Healthcare Information

This form is to request that additional restrictions be placed on the use and/or disclosure of protected healthcare information for
patient:
_____

The requested additional restrictions and the reasons for them are as follows:

_____

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If more space is needed, please, attach pages as needed.

I have read your Notice of Privacy Policies and I understand that you are not required to add these restrictions. I further understand that if you agree to add the requested restrictions, you will adhere to them and that I can cancel these added restrictions at any time I choose, but *only* by giving you written instructions advising you to do so.

Signature _____ Date _____
If this form is signed by a personal representative of the patient, please, complete the following:

Personal Representative's Name _____

Relationship to Patient _____

Mail or deliver the completed form to:

Dr. David R. Winchester
Suite 100
2500 Center Point Parkway
Center Point, AL 35215