(PLACE PATIENT ID LABEL HERE)

(ALL ENTRIES MUST HAVE DATE & TIME)

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: ______________________