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*North Carolina Infant Toddler Program*

*Request for Restrictions on Use and Disclosures of Health Information*

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|  | | | | | | | | | | | | | | |
| Identification | | | | | | | | | | | | | | |
| Child’s Name: |  | | | Date of Birth: | |  | | | Child’s SSN (optional): | | | |  | |
|  | | | | | | *MM/DD/YYYY* | | | | | | | | |
| Parent/Legal Guardian Address: | | |  | | | | | | | | | | | |
|  | | | | |  | |  | | | |  | | |  |
| Street | | | | | Apt# | | City | | | | State |  | | Zip |
|  | | | | | | | | | | | | | | |
| Parent/Legal Guardian Home Phone # | |  | | | | | | Work Phone # | |  | | | | |
|  | | | | | | | | | | | | | | |
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| Request | | | | | | | | | | | | | | |
| **I understand that I may request restrictions on specified uses and disclosures of my child’s health information. As such, I hereby request restriction of the use and disclosure of my own or my child’s health information that is created or maintained by this agency or provider in the following circumstances:** | | | | | | | | | | | | | | |
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| Parent/Legal Guardian Signature |  | Date |
|  |  |  |
| Legal Guardian Relationship/Authority |  | |

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| ***This Section for Agency Use Only*** | | | | | |
| Request APPROVED | | | | | |
| Agency Requirements | Notification to staff of restrictions | | | | |
|  | Notification to other agencies, as needed | | | | |
|  |  | | | | |
| Request DENIED |  | | | | |
| Reason for Denial: | May prevent or delay effective treatment. | | | | |
|  | Disclosure required by law | | | | |
|  | Other | | | | |
|  | |  |  |  |  | |
| By Staff | |  | Title |  | Date | |
|  | | | | | | |