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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 # |       |
|  |
|  |
| 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 |
|  |