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My signature on this form indicates that I have received a Notice of Privacy Information Practices. In the event that I have questions, I have been given the name of the Privacy Office, whose information is listed below, who will be able to answer my questions.

**PRIVACY OFFICER**

Alan Cutler, M.D.  
 30055 Northwestern Hwy., Suite 250  
 Farmington Hills, MI 48334  
 (248) 985-5000

I request the following restrictions to the use or disclosure of my PHI. I understand you may or may not agree to my request. I also understand if you agree to the restriction, if the restricted information is needed to provide me with emergency treatment, you may suspend the agreement and provide a health care provider with any needed information.

- I do not wish messages left on my voicemail at: \_\_\_\_\_
- I do not wish to be contacted by fax machine.
- I do not wish to be contacted by email.
- I wish only the following person(s) to receive my protected health information.

Name: \_\_\_\_\_ Relation \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name: \_\_\_\_\_ Relation \_\_\_\_\_ Date of Birth \_\_\_\_\_

Other: \_\_\_\_\_

Print Name

Date

Signature of Patient or Legal Representative

**OFFICE USE ONLY:**

- Accepted Restrictions
- Denied Restrictions

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