STATE OF MISSOURI
DEPARTMENT OF SOCIAL SERVICES

REQUEST FOR RESTRICTION OF HEALTH INFORMATION

INDIVIDUAL'S NAME	SOCIAL SECURITY NUMBER
INDIVIDUAL'S ADDRESS	BIRTH DATE
CITY, STATE, ZIP CODE	OTHER IDENTIFIER (E.G., DCN)

PLEASE SPECIFY THE INFORMATION TO BE RESTRICTED

PLEASE EXPLAIN WHY YOU DO NOT WANT THE INFORMATION DISCLOSED

Please indicate the individual, care provider, personal representative, or organization to whom access should be denied.

ENTITY'S NAME	RELATIONSHIP TO INDIVIDUAL

INDIVIDUAL OR PERSONAL REPRESENTATIVE SIGNATURE	DATE

Missouri Department of Social Services Use Only

☐ **Restriction is Accepted.** If accepted, return a copy of completed form to individual and send a copy to Divisional Privacy Officer. Place original form in individual's case file.

EMPLOYEE NAME	DIVISION/COUNTY	DATE

☐ **Recommend Denial of Restriction.** Explain recommendation and forward to Divisional Privacy Officer.

EMPLOYEE NAME	DIVISION/COUNTY	DATE

DIVISIONAL PRIVACY OFFICER DETERMINATION

☐ **Restriction is Accepted.** If accepted, return a copy of completed form to individual and send original to employee to place in individual's case file.

☐ **Restriction is Denied.** Return a copy of completed form to individual and send original to employee to place in individual's case file. Copy DSS Privacy Officer

DIVISIONAL PRIVACY OFFICER SIGNATURE	DATE