EXHIBIT 3

	Department of Social Services Request For Restriction of Health Information

Individual's Name	Social Security Number: Date of Birth: Other Identifier (e.g., DCN):
Individual's Address	
Please specify the information to be restricted:	
Please explain why you do not want the information disclosed:	

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

Individual's Name	Relationship to Individual

Signature of Individual or Personal Representative	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 for decision.

_____ _____ _____

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