**Department of Social Services**
Request For Restriction of Health Information

| Individual's Name | Social Security Number:<br>Date of Birth:<br>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