

**SOUND INPATIENT PHYSICIANS, INC.  
AND ITS AFFILIATED COVERED ENTITIES  
REQUEST FOR RESTRICTIONS ON COMMUNICATIONS**

**PATIENT NAME:** \_\_\_\_\_ **BIRTH DATE:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**TELEPHONE:** \_\_\_\_\_

By signing below, I affirm that I understand the following:

1. There are legal restrictions on the manner in which Sound may use or disclose health information about the above patient.
2. The patient or his or her authorized representative has the right to request restrictions on the way in which Sound uses or discloses my health information, in addition to the restrictions already imposed by law.
3. Sound is not required to grant my request for restrictions, unless, except, where otherwise required by law, the restriction relates to a disclosure to a health plan for purposes of carrying out payment or health care operations (and not for the purpose of carrying out treatment) and the health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.
4. If Sound grants my request for restrictions, the restricted information will not be used or disclosed except as required by law or to treat the patient in an emergency.
5. Either Sound or I can terminate our agreement to a restriction at any time by notifying the other party. If Sound terminates its agreement to a restriction, Sound will notify me and will continue to comply with the restriction for any information that was created prior to the date of termination.
6. I request the following restrictions with respect to the above patient's Protected Health Information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*If you are not the patient, please fill out the following information:*

**Name:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Address** (if different from above): \_\_\_\_\_

**Telephone** (if different from above): \_\_\_\_\_

***Please furnish a copy of any conservator/guardianship papers with this request.***

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**NOTE: ALL REQUESTS FOR PRIVACY MUST BE SUBMITTED IN WRITING ON THIS FORM TO  
THE PRIVACY OFFICER AT THE FOLLOWING ADDRESS:**

**Sound Physicians**  
Attn: Chief Compliance & Privacy Officer  
1222 Demonbreun Street, Suite 1601  
Nashville, TN 37203  
Phone: 1-855-768 6363  
Email: [compliance@soundphysicians.com](mailto:compliance@soundphysicians.com)

**SOUND INPATIENT PHYSICIANS, INC.  
AND ITS AFFILIATED COVERED ENTITIES  
REQUEST FOR RESTRICTIONS ON COMMUNICATIONS**

**Internal Use Only:**

**REQUEST IS:** \_\_\_\_\_ **APPROVED** \_\_\_\_\_ **DENIED**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**TERMINATION OF AGREEMENT:**

**DATE TERMINATED:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_