



### Request for Restriction and/or Confidential Communications

The undersigned individual or individual's personal representative hereby requests:

- Restriction of use and disclosure of protected health information;
- Removal of restriction of use and disclosure of protected health information; or
- Confidential communications

Individual Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Fax Number \_\_\_\_\_  
(include area code) (include area code)

Effective Date \_\_\_\_\_

#### RESTRICTION/REMOVAL OF RESTRICTION

*Alere is not required to agree to requests for restrictions, however, we will consider all reasonable requests.*

Describe the request for a restriction or for removal of a restriction:

\_\_\_\_\_

Name of Individual or  
Personal Representative *(PLEASE PRINT)* \_\_\_\_\_

Signature of Individual or  
Personal Representative \_\_\_\_\_ Date \_\_\_\_\_  
(If Personal Representative, include a description of authority to act for individual)

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

#### CONFIDENTIAL COMMUNICATIONS

Alternate Address \_\_\_\_\_

Alternate City/State/Zip \_\_\_\_\_

Alternate Telephone Number \_\_\_\_\_

Name of Individual or  
Personal Representative *(PLEASE PRINT)* \_\_\_\_\_

Signature of Individual or  
Personal Representative \_\_\_\_\_ Date \_\_\_\_\_  
(If Personal Representative, include a description of authority to act for individual)

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

**Please submit this form directly to:** Privacy Officer – Alere Medical, Inc. 1850 Parkway Place Suite 1200, Marietta, GA 30067. If you have any questions, please contact the Privacy Officer directly at 770-767-8191

*For Alere Use Only:* Date that this request was received by Alere \_\_\_\_\_  
Request Disposition \_\_\_\_\_ Approved \_\_\_\_\_ Denied