Confidential Medical Records Request Form

For Patients Requesting Confidential Status on Medical Records

Instructions: Please complete this form to request that your medical records be marked as confidential. Submit the completed form to the Privacy Office for review and approval at Privacy@closeKnit.com

Patient Information

Full Name:	_____
Date of Birth (MM/DD/YYYY):	_____
Medical Record Number:	_____
Contact Number:	_____
Email Address:	_____

Request Details

- **Reason for Requesting Confidential Status:**
  (Please provide a brief explanation for requesting that your medical records be marked confidential.)
  _____
  _____
- **Specific Records to be Marked Confidential:**
  (Please specify which records or types of information should be marked confidential, if applicable.)
  _____
  _____

Patient Authorization

I hereby request that the above-indicated medical records be marked as confidential. I understand that this may restrict access to my records and that only authorized personnel will be permitted to view or disclose this information.

Patient Signature:	_____
Date:	_____

Privacy Officer Review & Approval

Privacy Officer Name:	_____
Review Date:	_____
Decision:	☐ Approved ☐ Denied
Comments/Conditions (if any):	_____ _____

Privacy Officer Signature:	_____