**Restriction Request**

**Requester’s Name:**

**Address:**

**Phone Number:**

**Access Restriction Specifics:**

**Additional Comments:**

**Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Submit all restriction requests to:

Bay Pines VA Healthcare System

Privacy/FOIA Office (001PV)

P.O. Box 5005

Bay Pines, FL 33774