



REQUEST FOR LIMITATIONS OF PROTECTED HEALTH INFORMATION

PATIENT PLEASE NOTE: THE PRACTICE IS NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS.

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Street

_____ Apartment #

_____ City, State and Zip Code

Type of PHI to be restricted or limited: (Please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Home Phone | <input type="checkbox"/> Patient History |
| <input type="checkbox"/> Home Address | <input type="checkbox"/> Office Address |
| <input type="checkbox"/> Occupation | <input type="checkbox"/> Office Phone # |
| <input type="checkbox"/> Name of Employer | <input type="checkbox"/> Spouse's Name |
| <input type="checkbox"/> Visit Notes | <input type="checkbox"/> Spouse's Office Phone # |
| <input type="checkbox"/> Hospital Notes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Prescription Information | |

How would you like your PHI restricted?

Person(s) or class of persons authorized to receive PHI (Need Social Security # to authenticate):

- Spouse
- Sibling
- Parents
- Guardian
- Other _____

Signature of Patient or Legal Guardian

Date