



## REQUEST FOR LIMITATIONS AND RESTRICTIONS 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: \_\_\_\_\_

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

- ? Home phone #
- ? Home address
- ? Occupation
- ? Name of employer Visit notes
- ? Hospital notes
- ? Prescription information
- ? Patient history
- ? Office address
- ? Office phone #
- ? Spouse's name
- ? Spouse's office phone #
- ? Other \_\_\_\_\_

How would you like use and (or disclosure of) your PHI restricted? \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date