Request for Limitations and Restrictions of Protected Health Information (PHI)

Patient name: _____

Date of birth: _____

Patient address:

Street: _____

Apartment #: _____

City, State, ZIP: _____

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

_____ Home phone number
_____ Cell phone number
_____ Home address
_____ Occupation
_____ Name of employer
_____ Office visits records
_____ Hospital visits records
_____ Prescription information
_____ Patient history
_____ Office address
_____ Office phone number
_____ Parent's name
_____ Parent's phone number
_____ Spouse's name
_____ Spouse's phone number
_____ Other: _____

How would you like the use and/or disclosure of your PHI restricted?

_____

Signed by: _____

Relationship to Patient: _____

Date: _____