REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION (PHI)

Type of PHI to be restricted or limited:

Demographics:
- ☐ Home phone number
- ☐ Home address
- ☐ Parents' name(s)
- ☐ Parents' office phone number(s)
- ☐ Parents' employer(s)
- ☐ Parents' occupation(s)
- ☐ Other _____

Medical information:
- ☐ Patient history
- ☐ Visit notes
- ☐ Hospital notes
- ☐ Prescription information
- ☐ Other _____

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

_____

_____

Please note that the practice is not required to agree to your request. Please see our notice of privacy practices for more information regarding such requests.

_____	_____	_____
Date	Signature of Legal Guardian (or patient)	Print name of Legal Guardian (or patient)
	_____	_____**parent**_____
	Patient Name	Relationship to Patient