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REQUEST FOR LIMITATIONS AND RESTRICTIONS OF
PROTECTED HEALTH INFORMATION

Patient Name _____ D.O.B. _____
Address _____ M.R. # _____
_____

PLEASE CHECK ALL THE CATEGORIES OF PROTECTED HEALTH INFORMATION TO BE RESTRICTED:

___ Office Notes
___ Hospital Notes
___ Prescription Information
___ Psychotherapy Notes
___ Laboratory Data
___ X-ray results
___ Address
___ Phone number
___ Occupation
___ Spouse Information
___ Family History
___ Social History
___ Other _____

Please describe how to restrict the use or disclosure of your health information:

The practice is not required to agree to your request to restrict access to your Protected Health Information for Treatment, Payment, or Health Operations purposes, if such a request would be superseded by other legal and/or administrative requirements binding on this practice. Please refer to the *Notice of Privacy Practices* for additional information.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Name Relationship