
# 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:

_____

_____

_____

How would you like your PHI restricted?

_____

_____

_____

Signature of Patient or Legal Representative Date

If representative, state relationship:_____

Rev. 01/04