
**REQUEST FOR LIMITATIONS AND RESTRICTIONS OF
PROTECTED HEALTH INFORMATION**

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)

- | | |
|---|--|
| <input type="checkbox"/> Home phone # | <input type="checkbox"/> Patient history |
| <input type="checkbox"/> Home address | <input type="checkbox"/> Office address |
| <input type="checkbox"/> Occupation | <input type="checkbox"/> Office phone # |
| <input type="checkbox"/> Name of employer | <input type="checkbox"/> Spouse's name |
| <input type="checkbox"/> Visit notes | <input type="checkbox"/> Spouse's office phone # |
| <input type="checkbox"/> Hospital notes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Prescription information | |

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

Signature of Patient or Legal Guardian

Date