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www.abcdpediatrics.com

Request for limitation and restrictions of Protected Health Information

PATIENT PLEASE NOTE: **THE PRACTICE IS NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR PRIVACY PRACTICES FOR MORE INFORMATION REGARING SUCH REQUESTS.**

Patient Name: _____ Date of Birth: _____

Patient Address: _____
Street

_____
Apartment #

_____
City, State, Zip

Type of PHI (Protect Health Information) to be restricted or Limited: (Please Check all that apply)

☐	Home Phone #
☐	Home Address
☐	Occupation
☐	Name of Employer
☐	Visit Notes
☐	Hospital Notes
☐	Prescription Information

☐	Patient History
☐	Office Address
☐	Office Phone #
☐	Spouse's Name
☐	Spouses Office Phone #
☐	Other:

How would you like your PHI restricted? _____

_____

_____ _____
Signature of Patient or Legal Guardian Date

Date Received:		Privacy Office:	
Response:			
☐ Accept Request	☐ Deny Request	☐ Denied in part, Accepted in part	
Date:	Date	Date:	Reason for Denial: