REQUEST FOR LIMITATIONS & RESTRICTIONS OF PROTECTED HEALTH INFORMATION

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

Last Name	First Name	DOB
Address		
City	State	Zipcode

Type of PHI 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
- ☐ Spouse's office phone #
- ☐ Other

How would you like your PHI restricted?

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Signature of Patient or Legal Guardian ____________________ Date ____________

FORM LPHI