# White Hall Family Medicine Associates

Request for Limitations and Restrictions of
Protected Health Information

**Patient Please Note:**

*The practice is not required to agree to your request, though we do try to accommodate reasonable strictions, pleae see our notice of privacy practices for more information regarding such requests.*

Patient Name (Please Print) _____

Patient Date of Birth _____

Patient Address _____ Please Print

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Type of Protected Health Information (PHI) to be restricted or imited: (Please check all that apply)

☐ *All Patient Information demographices, insurance, Protect Health Information*

| | | | |
|---|---|---|---|
| ☐ | *Home Phone Number* | ☐ | *Patient History* |
| ☐ | *Occupation* | ☐ | *Office Address* |
| ☐ | *Nameof Employer* | ☐ | *Office Phone Number* |
| ☐ | *Visit Notes* | ☐ | *Spouse's Name* |
| ☐ | *Hospital Notes* | ☐ | *Spouse's Office Phone Number* |
| ☐ | *Prescription Information* | ☐ | *Other* |

Please list below persons you wish us to disclose your information to and any restrictions.

_____

_____

_____

_____ _____

Signature of Patient or Legal Guardian Date

For Internal Purposes ONLY: