Frederick Primary Care Associates, P.A.

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

PATIENTS 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: (Please check all that apply)

- ☐ Home Phone number
- ☐ Home Address
- ☐ Occupation
- ☐ Name of Employer
- ☐ Visit Notes
- ☐ Hospital Notes
- ☐ Prescription Information
- ☐ Patient History
- ☐ Office Address
- ☐ Office Phone Number
- ☐ Spouse's Name
- ☐ Spouse's Office Phone Number
- ☐ Other _____

How would you like your PHI restricted?

_____

_____

_____

_____ _____

Signature of Patient or Legal Guardian Date

FOR INTERNAL USE ONLY: