WOODSTOCK PEDIATRIC MEDICINE

REQUEST FOR LIMITATIONS AND 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.**

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)

- ☐ 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 us to limit or restrict your child's protected health information?

_____

_____

Printed name of person requesting restriction or limitation of PHI: _____

_____ _____
Signature of Legal Guardian or Patient (18 or older) Date
Original Signature Required