REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

Notice to Patient: Personal Best Health, LLC is not obligated to agree with your request. Please see our Notice of Privacy Practices for more information regarding such requests.

Patient Name: ____________________ Date of Birth: ______________
Street: ____________________ Apt #: ______________
City: ____________________
State: ____________________ Zip Code: ______________

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: ________________________________
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How would you like use and (or disclosure of) your PHI restricted?

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______________________________ ______________________________
Signature of Patient or Guardian Date

Request: ❑ Accepted ❑ Denied ____________________
Privacy Officer