ARTHRITIS AND RHEUMATISM ASSOCIATES, P.C.

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

PATIENT 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
- ☐ Office Phone
- ☐ Office Address
- ☐ Name of Employer
- ☐ Spouse's Name
- ☐ Visit Notes
- ☐ Consultation
- ☐ Hospital Notes
- ☐ Prescription Information
- ☐ Spouse's Office Phone #
- ☐ Other _____

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

_____

_____

To whom do you want the restrictions to apply?

_____

_____

_____ _____
Signature of Patient or Personal Representative Date