COMMUNITY CARE PHYSICIANS, P.C.
www.communitycare.com

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____ MRN: _____

Patient Address: _____
Street Apt. City, State

What information would you like to be restricted or limited (Check all that apply):

- ☐ Home Phone #
- ☐ Home Address
- ☐ Occupation
- ☐ Name of Employer
- ☐ Prescription
- ☐ Patient History
- ☐ Office Address
- ☐ Office Phone #
- ☐ Spouse's Name
- ☐ Spouse's Office Phone #
- ☐ Other: _____
- ☐ Visit Note _____ Date
  (Needs to be specific)
- ☐ Hospital Note _____ Date
  (Needs to be specific)

Who should this information be limited or restricted from? _____

Why is this request being made? _____

_____

PATIENT, PLEASE NOTE:

The practice is not required to agree to your request unless the disclosure is to a health plan for the purposes of payment or health care operations *and* the PHI relates solely to a health care item or service for which you have paid out-of-pocket in full. Please see our Notice of Privacy Practices for more information regarding such requests.

_____ _____
Signature Date

FOR OFFICE USE ONLY:

Did patient pay out of pocket in full? ☐ Yes ☐ No

Verified by: _____ _____
PRINT SIGN

☐ **Request is Granted** ☐ **Granted in Part** ☐ **Denied**

Decided by: _____ _____
PRINT SIGN

Comments: _____

_____