Winder Internal Medicine and Geriatrics Center P.C.

20 Satellite Dr. Ste 100, Winder, GA 30680
Phone (770) 586-0310, Fax (770) 586-0312

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

PLEASE NOTE: THIS 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 Address)

_____
(Apartment No.)

_____
(City, State, Zip)

Type of Protected Health Information 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 use and/or disclosure of your Protected Health Information restricted?

_____
_____
_____

_____ _____
Signature of Patient or Legal Guardian Today's Date