Request for Limitations and Restrictions of Protected Health Information (PHI)

– EAST PENN DERMATOLOGY, P.C.
1140 WELSH ROAD, SUITE 130
NORTH WALES, PA 19454

PATIENT PLEASE NOTE: GENERALLY, 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 (include apt #)

____
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 your PHI restricted?

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____ Patient / Parent / Legal Guardian / POA
Signature of Patient or Legal Guardian Date Circle One

____
Print Name