

**Marietta OB-Gyn AFFILIATES, P.A.**

**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 Address

\_\_\_\_\_  
City, State and Zip

Type of PHI to be restricted or limited (Please check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Home phone #             | <input type="checkbox"/> Patient history         |
| <input type="checkbox"/> Home address             | <input type="checkbox"/> Office address          |
| <input type="checkbox"/> Occupation               | <input type="checkbox"/> Office phone #          |
| <input type="checkbox"/> Name of employer         | <input type="checkbox"/> Spouse's name           |
| <input type="checkbox"/> Visit notes              | <input type="checkbox"/> Spouse's office phone # |
| <input type="checkbox"/> Hospital notes           | <input type="checkbox"/> Other                   |
| <input type="checkbox"/> Prescription information |  |

How would you like your PHI restricted?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date