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)

[] 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?

_____

_____

_____

_____ _____
Signature of Patient or Legal Guardian Date