Request for Limitations or Restrictions of Protected Health Information (PHI) Form

For Limitations or Restrictions of Protected Health Information (PHI) Form

Instructions: Please complete this form to request limitations or restrictions of protected health information. Submit the completed form to the Privacy Office for review and approval at Privacy@closeKnit.com

Patient Information

Full Name:	_____
Date of Birth (MM/DD/YYYY):	_____
Medical Record Number:	_____
Contact Number:	_____
Email Address:	_____
Today's Date:	_____

Request Details

- **Dates of the information to be restricted for example (treatment, date of office visit etc.).**
  _____
  _____
- **Describe the information to be restricted for example (Lab Results, physician notes).**
  _____
  _____
- **Please state the reason for your request.**
  _____
  _____

Patient Authorization

I hereby request to place limitations and/or restrictions on the use and/or disclosure of my Protected Health Information (PHI) as maintained by the above-named organization. I understand that this request applies to certain uses or disclosures of my PHI for treatment, payment, healthcare operations, or other purposes as permitted by applicable law. I understand that the organization is not required to agree to my requested restriction, except as otherwise required by law. If the organization agrees to the requested limitation or restriction, it will comply with the agreed-upon terms unless the information is needed to provide emergency treatment or as otherwise permitted or required by law.

Patient Signature:	_____
Date:	_____

Privacy Officer Review & Approval

Privacy Officer Name:	_____

Review Date:	_____
Decision:	☐ Approved ☐ Denied
Comments/Conditions (if any):	_____ _____
Privacy Officer Signature:	_____