

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