

NITRO PRIMARY CARE, PLLC

Request for Limitations & Restrictions of Protected Health Information (PHI)
Patient Please Note: The practice is not required to agree to your request. Please see our Notice of Privacy Practices that is located on the end table for more information regarding our procedures in following the HIPAA rules and regulations concerning patient's privacy.

PATIENT NAME: _____ DATE OF BIRTH _____

PATIENT ADDRESS: _____

I give the following person permission to have access to my medical history and to be involved in discussions that the physician may have with me during office visits. The following person may also be advised of tests results, etc that have been performed.

_____	_____
Name of person you give permission to	Relationship to patient
_____	_____
Name of person you give permission to	Relationship to patient
_____	_____
Name of person you give permission to	Relationship to patient

I would like to restrict the above person from having access to the following information:

_____ Visit Notes	_____ Hospital Notes
_____ Prescription Information	_____ Patient History
_____ Other _____	

The office staff/physician has my permission to discuss my health information (test results, surgery information, etc.) in the following ways:

_____ Home Phone (a message may be left on an answering machine)
 _____ Work Phone (a message may be left on _____ voice mail or _____ with a co-worker)
 _____ Cell Phone (a message may be left on voice mail)
 _____ Mail Only

Signature: _____ Date: _____