# Request for Limitations and Restrictions of Protected Health Information (PHI)

King Dermatology

PATIENT PLEASE NOTE: We may disclose your medical records only for the following reasons: treatment, payment, and healthcare operations as directed in our notice of privacy practices. If you would like to restrict or allow access to your PHI, please indicate below.

Patient Name: _____Date of Birth___/___/____

Patient Address: _____
Street

_____
Apartment number

_____
City, State, Zip

List all persons you want to access your PHI. (Emergency contact, family etc.)

Please check all the boxes of information that you would like restricted from the above persons.

- □ Home phone
- □ Name of employer
- □ Prescription information
- □ Office phone
- □ Other _____
- □ Home address
- □ Visit notes
- □ Patient history
- □ Spouse's name
- □ Occupation
- □ Hospital notes
- □ Office address
- □ Spouse's office phone

_____ ___/___/_____
Signature of Patient or Legal Guardian Date