

MMG Acct # _____

Date rec'd _____

Request for Limitations and Restrictions of Protected Health Information

Patient name _____ Date of birth _____
(please print)

Address _____
Street number City, state, zip

Home phone _____ Other phone _____

Type of protected health information (PHI) to be limited or restricted from use or disclosure
(check all that apply):

Demographic Information

- Home phone number
- Home address
- Occupation
- Employer
- Work address
- Work phone number
- Spouse's name
- Spouse's work phone number
- Other _____

Clinical Information

- Diagnosis
- Treatment
- Medications
- Office visit notes
- History and physical exam
- Procedure/operative notes
- Billing/payment history
- Other _____

How would you like your PHI restricted? Give names or relationships of people, names or types
of businesses/organizations that you do not want your PHI disclosed to.

NOTE: Your physician and McHenry Medical Group may not agree to your request. Please refer
to the Notice of Privacy Practices, Section 2, for details about your rights.

Signature _____ Date _____
Patient or Legal Representative