

Performing Sacred Work Everyday

## **REQUEST FOR LIMITATIONS AND 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 FOR MORE INFORMATION **REGARDING SUCH REQUESTS.**

Patient Name:		Date of Birth:
Patient Address:	Street	
	Apartment #	
	City, State and Zip Code	
Type of PH	need to	(Please check all that apply. Note: should you be referred to another physician, anything d will <i>NOT</i> be shared.)
	<ul> <li>Home phone #</li> <li>Home address</li> <li>Occupation</li> <li>Name of employer</li> <li>Visit notes</li> <li>Hospital notes</li> <li>Prescription information</li> </ul>	Patient History         Office address         Office phone #         Spouse's name         Spouse's office phone #         Other:

How may we use and/or disclose of your PHI restricted information?

Signature of Patient or Legal Guardian

Date



## PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize, Baptist Physician Network, to use and/or disclose certain Protected Health Information (PHI) about me to the following family members:

This authorization permits Baptist Physician Network to use and/or disclose medical and/or billing information directly related to my diagnosis and/or treatment. This information will be used or disclosed at the request of myself or the person(s) designated above. This authorization will not expire unless specifically revoked by either myself or the person(s) designated above.

I do not have to sign this authorization in order to receive treatment from Baptist Physician. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

Signed by:

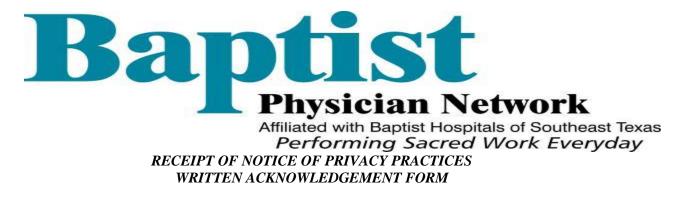
Signature of Patient or Legal Guardian

Relationship to Patient

Date

Print Name of Patient or Legal Guardian

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION



\_\_\_\_\_, have received a copy of Baptist Physician Network

Patient's Name

I,

Notice of Privacy Practices.

Signature of Patient

Date