Baptist Physician Network
Affiliated with Baptist Hospitals of Southeast Texas
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 PHI to be restricted or limited: (Please check all that apply. Note: should you need to be referred to another physician, anything checked will ***NOT*** be shared.)

_____ Home phone #
_____ Home address
_____ Occupation
_____ Name of employer
_____ Visit notes
_____ Hospital notes
_____ Prescription information
_____ 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

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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

_____ _____
Print Name of Patient or Legal Guardian | Date

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

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Baptist Physician Network
Patient's Name

Notice of Privacy Practices.

_____ _____
Signature of Patient Date