

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.)

<input type="checkbox"/> Home phone #	<input type="checkbox"/> Patient History
<input type="checkbox"/> Home address	<input type="checkbox"/> Office address
<input type="checkbox"/> Occupation	<input type="checkbox"/> Office phone #
<input type="checkbox"/> Name of employer	<input type="checkbox"/> Spouse's name
<input type="checkbox"/> Visit notes	<input type="checkbox"/> Spouse's office phone #
<input type="checkbox"/> Hospital notes	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Prescription information	

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