Internal Medicine of Ithaca, PC

2359 N Triphammaer Road, Ithaca, NY 14850

Request for Limitations and Restrictions of Protected Health Information

PATIENT PLEASE NOTE:

GENERALLY, 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: _____

_____

Type of PHI to be restricted or limited: (Please check all that apply)

❑ 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 would you like your PHI restricted?

_____
_____
_____

_____ _____

Signature of Patient or Legal Guardian Date