Boston Children's Health Physicians
Until every child is well™
formerly CWPW

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

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, Zip

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 use and (or disclosure of) your PHI restricted?

_____

_____

_____ _____
Signature of Patient or Parent/Legal Guardian Date