Request for Limitations and Restrictions of Protected Health Information

Please Note: Under government regulation we are not required to agree to your request. Please see our Notice of Privacy Practices for more information regarding such requests. If we are unable to approve your request, we reserve the right to reply within 30 days.

Patient Name _____ DOB _____ Chart #_____

Address _____ City/State _____ ZIP _____

I. CHART RESTRICTIONS (to identify a person/people we should NOT communicate with)

Type of Protected Health Information (PHI) to be restricted: (Please check all that apply)

☐ Patient History ☐ Prescription Information ☐ All Information *(see below)
☐ Visit Notes ☐ Address Info ☐ Other _____
☐ Hospital Notes ☐ Telephone Info

How would you like your PHI restricted? _____

_____

_____

*Important: Information will only be restricted from parties not involved in the provision of, payment for, or healthcare operations of your child's care. It will be necessary for us to continue to release information to your insurance company and/or other healthcare providers. If you have any concerns about this, please call our Compliance Officer at (910) 484-8009 ext 108.

_____ _____ _____
Signature of Parent/Legal Guardian | Printed Name of Parent/Legal Guardian | Date

II. CONFIDENTIAL COMMUNICATIONS (to identify a need for us to communicate with you in a special way).
THIS REQUEST CANNOT BE EXECUTED UNLESS COMPLETED

I, _____, am requesting that Cross Creek Pediatrics communicate with me in the alternative manner and/or location described below regarding my child's/children's health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996. Such restrictions are necessary to prevent disclosure that could endanger me. I understand that Cross Creek Pediatrics may deny this request if it imposes an unreasonable administrative burden.

Description of the Health Information that must be Communicated Confidentially - The following is a description of the specific health information to which this request applies:

_____

_____

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____ _____
Signature of Parent/Legal Guardian | Printed Name of Parent/Legal Guardian | Date