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Requests for Limitation of PHI

Patient's Name: Date of Birth:

Street Address: City, State, Zip:

PLEASE NOTE: Hamilton Dermatology will make every effort to accommodate reasonable requests, however we are not required to do so. If your request is denied, you will receive a written letter with an explanation. Please refer to our Notice of Privacy Practices for more information.

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

☐ Home Phone Number	☐ Office Phone Number	☐ Visit Notes
☐ Home Address	☐ Office Address	☐ Prescription Information
☐ Occupation	☐ Spouse's Name	☐ Patient History
☐ Name of Employer	☐ Spouse's Office Phone	☐ Other:

How would you like your Protected Health Information restricted?

Signature of Patient or Legal Guardian Date

Printed Name of Patient or Legal Guardian