UROLOGY, P.C./UROLOGY SURGICAL CENTER REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

PLEASE NOTE: THE PRACTICE IS NOT REQUIRED TO AGREE, BUT WILL CONSIDER ALL REQUESTS FOR LIMITATIONS AND RESTRICTIONS. SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION

Patient Name: ______________________________Date of Birth: ________________

Patient Address: ____
Street Apartment #

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City, State and Zip Code

I would like my PHI restricted in the following manner: _________________________

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Signature of Patient or Legal Guardian Date

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Signature of UPC Staff Member

Revised 12/30/08