WOMEN'S HEALTH CARE, LLC

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 Legal Guardian Date

FOR INTERNAL PURPOSES ONLY:

Date Request Received:_____

WOMEN'S HEALTH CARE, LLC

REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____
Street

_____
Apartment #

_____
City, State Zip

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is $0.25 per page, with a minimum charge of $25.00.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Print Name of Patient or Legal Guardian

FOR INTERNAL PURPOSES ONLY:

Date Request Received:_____

WOMEN'S HEALTH CARE, LLC

REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth:_____

Patient Address: _____
Street

_____
Apartment #

_____
City, State Zip

Type of Entry to be Amended: _____

- ☐ *Visit note*
- ☐ *Nurse note*
- ☐ *Hospital note*
- ☐ *Prescription information*
- ☐ *Patient history*

Please explain how the entry is inaccurate or incomplete.

_____

_____

Please specify what the entry should say to be more accurate or complete.

_____

_____

_____ _____
Signature of Patient or Legal Guardian Date

FOR INTERNAL PURPOSES ONLY:

Date Request Received:_____

Amendment has been: ☐ Accepted

☐ Denied

☐ Denied in part, Accepted in part

If denied (in whole or in part)*, check reason for denial:

☐ PHI was not created by this organization.

☐ PHI is not available to the patient for inspection in accordance with the law.

☐ PHI is not a part of patient's designated record set.

☐ PHI is accurate and complete.

Comments from healthcare provider who provided service:

_____

_____

_____

_____

Name of Staff Member Completing Form: _____

Title: _____

_____ _____

Signature of Healthcare Provider Who Provided Service Date

*If your request has been denied, in whole or in part, you have the right to submit a written statement disagreeing with the denial to the practice. If you do not provide us with a statement of disagreement, you may request that we provide to you copies of your original request for amendment, our denial, and any disclosures of the protected health information that is the subject of the requested amendment. Additionally, you may file a complaint with our Privacy Officer or the Secretary of the U.S. Department of Health & Human Services.