WILKINSON EYE CENTER, P.C.

dedicated to EXCELLENCE in eye care

Certified Doctors of Ophthalmology

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REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION (PHI)

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

___ Prescription information

___ Patient history

___ Office address

___ Office phone #

___ Spouse's name

___ Spouse's office phone #

___ Other: _____

How would you like the use and/or disclosure of your PHI restricted?

_____

_____

Signature of patient: _____ Date: _____

Signature of guardian: _____ Date: _____

Printed name of legal guardian: _____