

Valdosta State University

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

- Speech Clinic
- Student Health Services
- Athletic Department
- Human Resources
- Other. Please Specify _____

PATIENT/EMPLOYEE PLEASE NOTE:

**VALDOSTA STATE UNIVERSITY IS NOT REQUIRED TO
AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF
PRIVACY VALDOSTA STATE UNIVERSITY FOR MORE
INFORMATION REGARDING SUCH REQUESTS.**

Patient/Employee Name: _____ Date of Birth: _____

Patient/Employee Address:

Street

Apartment #

City, State Zip

Type of PHI to be restricted or limited: (Please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Home phone # | <input type="checkbox"/> Patient/Employee history |
| <input type="checkbox"/> Home address | <input type="checkbox"/> Office address |
| <input type="checkbox"/> Occupation | <input type="checkbox"/> Office telephone number |
| <input type="checkbox"/> Name of employer | <input type="checkbox"/> Spouse's name |
| <input type="checkbox"/> Visit notes | <input type="checkbox"/> Spouse's office telephone number |
| <input type="checkbox"/> Hospital notes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Prescription information | |

How would you like use and (or disclosure of) your PHI restricted?

Signature of Patient/Employee or Legal Guardian

Date

FOR INTERNAL PURPOSES ONLY:

Date Request Received: _____