REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ Date of Birth: ____________________

Patient Address: ____

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Which of the following communication means are appropriate/acceptable for SMG to communicate with you: (Please check all that apply)

_____ Home phone # - leave message to return call – no particulars

_____ Home phone # - leave message with particulars

_____ Work phone # - leave message to return call – no particulars

_____ Work phone # - leave message with particulars

_____ Cell phone #: ________________ - leave message to return call – no particulars

_____ Cell phone #: ________________ - leave message with particulars

Who are you authorizing SMG to discuss your health situation with: (Please list all names)

No one ________

Spouse (Name: ____)

Child (Name: ____)

Sibling (Name: ____)

Other (Name: ____)

Other (Name: ____)

IN CASE OF EMERGENCY, OR IF WE ARE UNABLE TO REACH YOU, WHOM MAY WE CONTACT?

Name: ______________________________________ Relationship: ______________________

Phone: ______________________________________; ______________________________

I understand that:

- I may revoke this authorization in writing at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management (Medical Records) Department. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will expire on ______________________. If no date is specified, this authorization will expire one year after the date it is signed by the Patient or the Patient's Legal Representative.
- I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may or may not be protected by federal privacy laws or regulations.
- I understand authorizing the use or disclosure of the information identified above is voluntary. I do not need to sign this form to ensure healthcare treatment.
- I have the right to receive a copy of this authorization.

I have received a copy of Southern Medical Group's Notice of Privacy Practices.

______________________________________ ______________________

Signature of Patient or Legal Guardian Date