



**REQUEST FOR LIMITATIONS AND RESTRICTIONS OF  
PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_

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
- \_\_\_\_\_ e-mail address: \_\_\_\_\_
- Other: \_\_\_\_\_

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

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date