

**Pulmonary and Sleep Medicine Center of Winder**

20 Satellite Dr. Ste 200, Winder, GA 30680  
Phone (770) 586-0300, Fax (770) 586-0311

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

**PLEASE NOTE: THIS 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 Address)

\_\_\_\_\_

(Apartment No.)

\_\_\_\_\_

(City, State, Zip)

Type of Protected Health Information to be restricted or limited: (Please check all that apply)

- Home phone number
- Home address
- Occupation
- Name of employer
- Visit notes
- Hospital notes
- Prescription information
- Patient history
- Office address
- Office phone number
- Spouse's name
- Spouse's office phone number
- Other \_\_\_\_\_

How would you like use and/or disclosure of your Protected Health Information restricted?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
Today's Date