

Hematology Oncology Associates of Houston

Request for Protected Health Information Restrictions

Patient Name: _____ Date of Birth: _____

How would you like your protected health information restricted? Are there specific addresses or phone numbers where you do NOT want to be contacted? Are there specific individuals who should be specifically restricted from having any access to your health information? Are there any other restrictions you would like to mention?

Date you received your privacy notice: _____

Signature: _____

Log to track Disclosures of PHI by date and description defining the requestor and receiver: