

FINGER LAKES WOMEN'S HEALTH, PLLC

OBSTETRICS AND GYNECOLOGY

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Request for Limitations and Restrictions of Protected Health Information

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Street

Apartment #

City, State Zip

Please Circle yes or no for the following questions:

Are we able to leave appointment information on an answering machine or with a family member?

YES

NO

Are we able to send information to your home address?

YES

NO

Are we able to contact you at work if necessary?

YES

NO

Work # (_____) _____

Are we able to share your medical records with other doctors (such as specialists) in regards to your patient care?

YES

NO

List **names** (and relationship) of family or friends that we can discuss your medical information with, **or put NONE**: _____

What may be discussed with them? Please circle what we may discuss:

Appointment/Scheduling

Visit notes

Hospital notes

Billing Information

Patient history

Prescription information

I have been given access to a copy of FLWH's HIPAA privacy policy.

Signature of Patient

Date