REQUEST TO AMEND OR RESTRICT PHI

PATIENT INFORMATION

Name: ____ **Date of Birth:** _____________
Address: _____________________________ **City:** __________ **State:** _______ **Zip:** ________
Phone #: _____________________________ **Email:** ___________________________________

INFORMATION TO BE AMENDED

Date(s) of service: ____ □ not applicable
Information to be amended: □ additional page(s) attached

____
____
____

Reason for amendment: ____
____

INFORMATION TO BE RESTRICTED

Date(s) of service: ____ □ All dates of service
Information to be restricted: □ additional page(s) attached

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Individual(s) and/or Organizations restricted from use/disclosure:

Name: _________________________________ Relationship to Patient: _____________________
Phone #: _________________________________ Email: __________________________________
Address: _________________________________ City: ______________ State: ___ Zip: ________
Name: _________________________________ Relationship to Patient: _____________________
Phone #: _________________________________ Email: __________________________________
Address: _________________________________ City: ______________ State: ___ Zip: ________

AUTHORIZATION

By signing below, I understand that:

- Restorative Therapies cannot amend records created by other providers.
- Restorative Therapies is not required to agree to this request and is not permitted to grant restrictions that violate the law. If your request is denied, you will receive a written explanation within 60 days.
- If Restorative Therapies agrees to your request to restrict protected health information (PHI), this restriction will remain in effect until revoked in writing or (if the patient is a minor under age 18) until the patient turns 18 years of age.

Signature of Patient or Representative*: _______________________ **Date:** _________________

Name of Representative: _______________________________ Relationship to Patient: __________

**** If not signed by the patient or parent of a minor child, authorizing documentation is required.***
(e.g. Power of Attorney or Legal Guardianship)