



Children's
of Alabama

CHILDREN'S OF ALABAMA (COA) REQUEST FOR RESTRICTION OF PROTECTED HEALTH INFORMATION			
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Patient Name: (Please print)		Request Date:	
Street Address		Birth Date:	
City/State/Zip:		Phone Number:	

Request for Restriction	
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Please describe whose access is restricted:	
Dates Requested For Restriction:	I request a restriction for my child's records with the following dates: From: _____ To: _____
Please describe what information you are requesting to restrict.	

I represent that I am the parent/legal guardian of the patient and have the authority to request this restriction. I understand that COA may not be able to accept this request if prohibited by law.

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____ Date: _____

Patient Signature if 19 or older: _____ Date: _____

Witness Signature: _____ Date: _____

**** RETURN FORM TO THE COA PRIVACY OFFICER ****

Mailing Address: COA Privacy Officer, Children's of Alabama, 1600 7th Avenue South, Birmingham, AL 35233

Fax: (205) 638-2468

Email: HIPAA@ChildrensAL.org

Phone for Questions: (205) 638-5959