Children's of Alabama

CHILDREN'S OF ALABAMA (COA)
REQUEST FOR RESTRICTION OF PROTECTED HEALTH INFORMATION

Patient Name: (Please print)		**Request Date:**	
Street Address		**Birth Date:**	
City/State/Zip:		**Phone Number:**	

Request for Restriction

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