Children's of Alabama

CHILDREN'S OF ALABAMA
PHYSICIANS TO CHILDREN
REQUEST FOR RESTRICTION
PROTECTED HEALTH INFORMATION

Patient Information

Patient Name: (Please print)		**Request Date:**	
Street Address and phone #:		**Birth Date:**	
City/State/Zip:		**Date of Request:**	

Request for Restriction

Please describe whose access is restricted:	
Dates Requested For Restriction:	I would like a restriction for my child's records with the following dates: From: To:
Please describe what information you'd like restricted.	

Signature of Parent/Legal Guardian/Patient

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

Parent/Legal Guardian Signature:_____Date:_____

Patient Signature if 14 or older:_____Date:_____

Witness Signature:_____Date:_____

INTERNAL USE ONLY: Date Received:_____ Date Sent:_____
Comments:_____
Employee Processing Request:_____MIS Initials:_____HIPAA Initials:_____