Lifetime Insight, LLC
440 Regency Parkway Dr., Suite 136
Omaha, NE 68114
Office: 402-934-7404
Fax: 402-909-0196

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

PATIENT PLEASE NOTE: GENERALLY, THE PRACTICE IS NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS.

Patient Name: ______________________________

Patient Address: ______________________________

(Street and Apartment Number)

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(City, State, Zip)

Type of PHI to be restricted or limited (Please check all that apply):

- ☐ Home phone number
- ☐ Office phone number
- ☐ Prescription information
- ☐ Home address
- ☐ Office address
- ☐ Visit notes
- ☐ Occupation
- ☐ Spouse's name
- ☐ Other:
- ☐ Name of employer
- ☐ Spouse's office phone number

How would you like your PHI restricted?

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____

(Signature of Patient) (Date)

OR

____

(Signature of guardian or authorized representative) (Relationship to patient)

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ReqRestrPHI