TGS ENDODONTICS

Richard S. Shapiro, D.D.S.

www.tgsendo.com

The Medical Quarters
5555 Peachtree Dunwoody Rd., Suite 275
Sandy Springs, GA 30342
404-256-4772 Phone

Request For Limitations and Restrictions on use, disclosure of Protected Health Information (PHI)

PATIENT PLEASE NOTE: TGS Endodontics IS NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS. YOUR REQUEST NEEDS TO BE LEGIBLE, PRECISE AND COMPLETE OR IT MAY BE DENIED.

Patient Name _____ (Please print)

Date Of Birth _____

Patient Address

Street _____

Apartment # _____

City, State Zip _____

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

- ☐ Home phone #
- ☐ Home address
- ☐ Occupation
- ☐ Name of employer
- ☐ Visit notes
- ☐ Treatment notes
- ☐ Prescription information
- ☐ Patient history
- ☐ Office address
- ☐ Office phone #
- ☐ Spouse's name
- ☐ Spouse's office phone #
- ☐ Other _____

How would you like TGS Endodontics to restrict its use and/or disclosure of your PHI? Your **request needs to be legible, concise and clear or it may be denied.**

1) Description of information to be restricted: _____

2) Requested restricted use and/or disclosure: _____

Please check the appropriate box.

- ☐ Requested restricted use of your PHI by TGS Endodontics
- ☐ Requested restricted disclosure of your PHI by TGS Endodontics
- ☐ Requested restricted use and disclosure of your PHI by TGS Endodontics

I understand that TGS Endodontics is not required to agree to this requested restriction, but that if it does agree, it will abide by its agreement. I understand that, if TGS Endodontics agrees to the restriction, it may use and disclose the restricted information in certain circumstances, such as for emergency treatment or public health disclosures among other circumstances.

_____ _____

Signature of Patient **Date**

If signing as Legal Guardian or Patient's Personal Representative (You will need to provide us with a copy of document(s) which give you that legal authority.):

_____ _____

Patient's Legal Guardian or Personal Representative **Date**

Printed Name: _____

Relationship to Patient: _____

Dentist or TGS Endodontics' Staff Signature:

_____ _____

Date

For Dental Office Use Only

- ☐ Agree to
- ☐ Not Agree to

Signature: _____ Date: _____

Print Form

(TGS Revised 2/7/2014)