BAYLOR GENETICS

COMPLIANCE DEPARTMENT
2450 HOLCOMBE BLVD.
SUITE 2210
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

Patient Request For Restriction Form

45 Cfr §164.522

Patients or their personal representatives can complete this form to request a restriction or limitation on use/disclosure of the patient's Protected Health Information (PHI) maintained by Baylor Genetics. Please submit the completed form to the address or fax number above.

PATIENT INFORMATION

Requested Date (MM/DD/YYYY) _____ / _____ / _____

Patient's Full Name _____

Birth Date (MM/DD/YYYY) _____ / _____ / _____

Phone Number _____

Fax Number _____

Address _____

City _____

City _____

Zip _____

Email Address _____

PATIENT REQUEST FOR RESTRICTION OR LIMITATION OF PHI

Date(s) of service associated with PHI/information to be restricted _____ / _____ / _____

Description of PHI/information to restrict:

Reason for Request (optional): _____

SIGNATURES

Patient's Signature _____

Date Signed (MM/DD/YYYY) ____ / ____ / _____

Patient's Personal Representative** Signature _____

Date Signed (MM/DD/YYYY) ____ / ____ / _____

Printed Name _____

Relationship to Patient _____

**Attach documents demonstrating your authority to act on behalf of the patient if you are not the parent. (e.g., A valid power of attorney letter, court order; guardianship papers)