

**PATIENT REQUEST FOR RESTRICTION OF PHI FORM**

45 CFR §164.522

This form allows patients or their personal representatives to request restrictions on the use or disclosure of protected health information (PHI) maintained by Baylor Genetics. Please submit the completed form to the address below or compliance@baylorgenetics.com.

Attn: Baylor Genetics Compliance
2450 Holcombe Blvd.
Suite 2210
Houston, TX 77021

PATIENT INFORMATION____ / ____ / ____
Requested Date (MM/DD/YYYY)_____
Patient's Full Name____ / ____ / ____
Birth Date (MM/DD/YYYY)_____
Phone Number_____
Fax Number_____
Address_____
City_____
State_____
Zip_____
Email Address**REQUEST FOR RESTRICTION DETAILS**____ / ____ / ____
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 documentation demonstrating authority to act on behalf of the patient, if applicable (e.g., a valid power of attorney letter, court order, guardianship papers, etc.).