

**EXHIBIT 8**

\_\_\_\_\_  
**PRACTICE NAME**

**REQUEST FOR LIMITATIONS AND RESTRICTIONS OF  
PROTECTED HEALTH INFORMATION**

**PATIENT PLEASE NOTE: 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: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_  
Street

\_\_\_\_\_  
Apartment #

\_\_\_\_\_  
City, State Zip

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

- |   |  |
|---|--|
| <input type="checkbox"/> Home phone #             | <input type="checkbox"/> Patient history         |
| <input type="checkbox"/> Home address             | <input type="checkbox"/> Office address          |
| <input type="checkbox"/> Occupation               | <input type="checkbox"/> Office phone #          |
| <input type="checkbox"/> Name of employer         | <input type="checkbox"/> Spouse's name           |
| <input type="checkbox"/> Visit notes              | <input type="checkbox"/> Spouse's office phone # |
| <input type="checkbox"/> Hospital notes           | <input type="checkbox"/> Other _____             |
| <input type="checkbox"/> Prescription information |  |

How would you like your PHI restricted?

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

FOR INTERNAL PURPOSES  
ONLY: