

FORM C

REQUEST TO LIMIT PROTECTED HEALTH INFORMATION

Patient Name:	
Date of Birth:	SSN: XXX-XX
Address where you want the ar	mendment response sent:
to the information maintained "ADPH"). If you would like to	our request to limit your protected health information only applies by the Alabama Department of Public Health (hereinafter request a limitation of your protected health information created ealth care provider, a separate request must be submitted to that
	REQUESTED AMENDMENT:
I request that ADPH limit (des	cribe the information you would like restricted):
	bed above to be made to the protected health information in my
designated record set (medical	record) maintained or created by ADPH.
Date of record or information y	ou would like to limit:
I would like this information li	mited because (state specific reason for request):
[Signature/Title, if legal re	presentative*] Date
[51ghature/11tic, if legal fe	presentative

^{*}May be requested to submit evidence of representative status.

REQUEST APPROVED:		
Ву:		
By:Signature	Title	Date
REQUEST DENIED;		
By:Signature		
Signature	Title	Date
 The information was not creed. The information is not part of the information is not available policy regarding individual and the information is not available. 		at to the ADPH's
 The information is accurate a 	and complete,	
After submitting your disagree why your request was denied. hearing will be held.	ment in writing, you will be giv You will receive sufficient notice	en an opportunity for a hearing or ce of the time and place that the
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