313 N. Jefferson St.
Perry, FL 32347
850-584-2674

MORGAN
FAMILY DENTISTRY

10820 Marvin Jones Blvd.
Dowling Park, FL 32064
386-658-5870

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

Patient Name_____**Date of Birth**_____
Patient
Address_____
_____

Which of the following communications means are appropriate/acceptable for MFD to communicate with you? Please check all that apply.

☐ Home phone#-leave message (to return call-no particulars or with particulars)
☐ Work phone#-leave message (to return call-no particulars or with particulars)
☐ Cell phone#- leave message (to return call-no particulars or with particulars)

Who are you authorizing MFD to discuss your health situation with: Please list all names

No one ☐
Spouse (Name)_____
Child (Name)_____
Sibling (Name)_____
ACV Coordinator (Name)_____
Other (Name)_____

IN CASE OF EMERGENCY, OR IF WE ARE UNABLE TO REACH YOU, WHOM MAY WE CONTACT?

Name_____**Relationship**_____
Phone_____

I UNDERSTAND THAT:

- **I may revoke this authorization in writing at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management. I understand that the revocation will not apply to information that has already been released in response to this authorization.**
- **This authorization will expire on**_____**if no date is specified, this authorization will expire one year after the date is signed by the patient or the patient's representative.**
- **I have the right to receive a copy of this authorization.**

_____

Signature of Patient or Legal Guardian **Date**