Nebraska Urology

NEBRASKA UROLOGY/UROLOGY SURGICAL CENTER REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

PLEASE NOTE: THE PRACTICE IS NOT REQUIRED TO AGREE, BUT WILL CONSIDER ALL REQUESTS FOR LIMITATIONS AND RESTRICTIONS. SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION

Patient Name: _____Date of Birth: _____

Patient Address: _____
Street Apartment #

_____
City, State and Zip Code

I would like my PHI restricted in the following manner: _____

_____

_____

_____

_____

_____ _____
Signature of Patient or Legal Guardian Date

_____
Signature of NU Staff Member