

East Texas Infectious Disease Consultants, PLLC

**Form for Granting Access/Restriction to Private Health Information (PHI)**

I understand that I can grant/restrict access to my Private Health Information (PHI) at East Texas Infectious Disease Consultants, PLLC (ETIDC). The health information I used and disclosed to carry out treatment, payment or operations such as continuity of care with all my physicians and hospital.

I have been given the opportunity to review the practice’s policy outlining the requirements for granting access/restriction to health information. I understand that ETIDC reserves the right to deny this request dependent upon the circumstances.

I request the following person/people to have **access** to my Private Health Information.

Name(s)—Please print	Information Access Preferences		
1. _____	<input type="checkbox"/> All	<input type="checkbox"/> Restricted*	<input type="checkbox"/> Financial
2. _____	<input type="checkbox"/> All	<input type="checkbox"/> Restricted*	<input type="checkbox"/> Financial
3. _____	<input type="checkbox"/> All	<input type="checkbox"/> Restricted*	<input type="checkbox"/> Financial
4. _____	<input type="checkbox"/> All	<input type="checkbox"/> Restricted*	<input type="checkbox"/> Financial
5. _____	<input type="checkbox"/> All	<input type="checkbox"/> Restricted*	<input type="checkbox"/> Financial

\*Clinical Information Restricted—If you checked this box above, please specify what clinical information you **do not** wish to share with the person(s) in the above boxes:

- Sexually transmitted disease(s)
- Pregnancy
- Terminal illness
- Mental/behavioral health
- Other \_\_\_\_\_

Place patient label here

Preferred means of contact:  
 Phone (home/answering machine): \_\_\_\_\_  
 Work/voice mail: \_\_\_\_\_  
**Date signed:** \_\_\_\_\_

**Patient signature**

**Witness signature**

\*Verbal requests required unique identified, e.g. the last four digits of patient’s social security number.