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EXHIBIT E
GUAM COMMUNITY HEALTH CENTERS
(NORTHERN AND SOUTHERN REGION COMMUNITY HEALTH CENTERS)

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

PATIENT PLEASE NOTE: **THE GUAM COMMUNITY HEALTH CENTERS ARE NOT REQUIRED TO AGREE TO YOUR RQUEST. 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)

- ☐ Home phone #
- ☐ Home address
- ☐ Occupation
- ☐ Name of employer
- ☐ Progress notes
- ☐ Hospital notes
- ☐ Prescription information
- ☐ Patient history
- ☐ Office address
- ☐ Office phone #
- ☐ Spouse's name
- ☐ Spouse's office phone #
- ☐ Other _____

How would you like your PHI restricted?

_____

_____

_____

Print Name of Patient or Legal Guardian: _____

_____ _____
Signature of Patient or Legal Guardian **Date**

FOR INTERNAL PURPOSES ONLY: