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Form for Granting Access/Restriction
To Private Health Information

I understand that I can grant restrict access to my Private Health Information at David J. Lim, M.D., P.A. The health information is used and disclosed to carry out treatment, payment or operations.

I have been given the opportunity to review the clinic's policy outlining the requirements for granting access/restricting health information. I understand that David J. Lim, M.D., P.A. reserves the right to deny this request upon the circumstances.

I request the following person people to have access to my Private Health Information:

Name(s) (Please Print)

1. _____ : Relation: _____ Phone: _____
2. _____ : Relation: _____ Phone: _____
3. _____ : Relation: _____ Phone: _____
4. _____ : Relation: _____ Phone: _____
5. _____ : Relation: _____ Phone: _____

If you do not wish for anyone to have access to your health information, please leave blank above.

May we leave your healthcare information on your voicemail or answering machine?

Yes _____ No _____

Preferred means of contact:

Name (Print Print)

Phone: Home: _____
Cell: _____

Patient Signature

Witness Signature