Bishnu P. Verma, M.D., P.A.

Internal Medicine **Diplomate ABIM in Internal Medicine**

American College of Physicians
Internal Medicine/Doctors for Adults

Request for Restrictions of PHI

I, _____, understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or other healthcare operations.

You may contact me by e-mail, mail at home and/or at the following address:

E-mail: _____

Address: _____

_____

You may contact me or leave me a massage at home and at the following telephone number:

#1. _____

#2. _____

You may discuss any portion of my medical record with the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

(If you are 18 years old, must be signed by parent or guardian)

1555 Saxon Boulevard, Suite 601, Deltona, FL 32725, Telephone (386) 860-2600, Fax (386) 860-7216