AmeriHealth
ADMINISTRATORS

Request for Limitations and Restrictions of Protected Health Information

PARTICIPANT PLEASE NOTE: AMERIHEALTH ADMINISTRATORS IS NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS.

Participant Name: _____ Date of Birth: _____

Participant Address: _____
Street Apartment # City, State Zip

Type of PHI to be restricted or limited: _____

_____

_____

_____

_____

_____

How would you like your PHI restricted? _____

_____

_____ _____
Signature of Participant or Legal Guardian Date

FOR INTERNAL USE ONLY:

Date Request Received _____