Ridgeview Dental
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REQUEST FOR ACCESS AND RESTRICTIONS OF Personal Health Information (PHI)

Patient Name_____ SSN_____

Address_____ DOB_____

The following may have access to my personal health information (PHI)
(List full name and relationship)

1._____
2._____
3_____

No time period of access ____
Specific time period of access_____

The following may not have access to my personal health information
(List full name and relationship)

1._____
2._____
3._____

No time period of access____
Specific time period of access_____

Signature_____ Date_____
Patient, parent/guardian if minor)