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**REQUESTED RESTRICTION ON USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FORM**

I, \_\_\_\_\_, give permission to the Association of Specialty Physicians, Inc. to leave information on an answering machine. I understand this may pertain to medical information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I also give permission for the following people to be given information: (Please check all that apply)

- Spouse
- Mother
- Father
- Children
- Grandparents
- Other, please list person(s) name(s)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Right to revoke:** You may revoke this authorization at any time except to the extent that we have relied on this authorization. To revoke this authorization, you must submit a written revocation to our Privacy Officer at the following address: Andrew S. Kaye, MD, 1030 Beaner Hollow Road, Beaver, PA 15009.