SUNY DOWNSTATE Health Sciences University

REQUESTS FOR ADDITIONAL PRIVACY PROTECTION

Patient Name: _____
Last Name First Name MI

Address: _____ Telephone: _____(home)

_____ _____(cell)

_____ DOB: _____

Request for Restriction

As our patient, you have the right to request that we restrict the way we use or disclose your protected health information for treatment, payment or healthcare operations. SUNY Downstate Health Sciences University is not required to agree to your request for a restriction. If we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or to comply with the law.

What information do you want to restrict?

_____

_____

_____

How do you want us to restrict the information and when should the restrictions apply?

_____

_____

_____

Request for Confidential Communication

As our patient, you have the right to request that we communicate with you about your medical matters in a method or location that is more confidential for you. We will not ask you the reason for your request.

What is the alternative method or location of communication that you are requesting?

_____

_____

_____

How will payment, if any, be handled if we agree to communicate with you through this alternative method or location?

_____

_____

_____

By signing below, I certify that I am requesting that SUNY Downstate Health Sciences University - University Hospital of Brooklyn afford me with additional privacy protections as stated above.

_____ _____
Print Name of Patient/ Personal Representative Signature of Patient/ Personal Representative

_____ _____
Description of Personal Representative's Authority Date

SUNY DOWNSTATE Health Sciences University

NOTICE OF ADDITIONAL PRIVACY PROTECTION REQUEST REVIEW

[Date]

[Patient Name]
[Street Address 1]
[Street Address 2]
[City, State Zip Code]

Re: Request for Additional Privacy Protection

Dear [Patient Name]:

This letter responds to your request, received from you on _____, that we

- ❑ RESTRICT YOUR INFORMATION

- ❑ CONTACT YOU AT AN ALTERNATIVE METHOD OR LOCATION.

We have reviewed your request and:

❑ Agree to your request for additional privacy protection in the following manner:

_____

_____

_____

❑ Deny your request because of the following reason:

- ❑ The additional privacy protection may cause us to violate a law.
- ❑ The additional privacy protection may cause us to violate professional standards.
- ❑ Our information systems make it unfeasible to accommodate your request.
- ❑ Your request may impede us from treating you appropriately.
- ❑ You have not specified an alternative payment arrangement.
- ❑ We do not feel that your request is in your best interests as our patient.
- ❑ Your request may impede us from communicating with you effectively.
- ❑ We cannot abide by your request consistently.
- ❑ Your request places an unreasonable financial burden upon us.

Please contact the Patient Relations Department at (718) 270-1111 if you have questions or concerns.

A COPY OF THIS NOTICE MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD.

SUNY DOWNSTATE Health Sciences University

MODIFICATION/ TERMINATION OF RESTRICTION

This is a modification or termination of the patient's request of ___/___/_____ for a restriction of his/her information.

This modification or termination is a result of a request from:

- ❑ Patient
- ❑ SUNY Downstate Health Sciences University

MODIFICATION: The patient's request for restriction is being modified in the following manner:

_____

_____

_____

_____

TERMINATION: The patient's request for any restriction, other than restrictions on PHI paid out of pocket, is being terminated. Document reason (if any):

_____

_____

_____

_____

❑ Patient agrees to modification/ termination.

_____ _____

Signature of Patient or Personal Representative Date

❑ Patient does not agree to modification/ termination.

Modification/ Termination is only applicable after patient notification date of ___/___/_____

_____ _____

Signature of Patient or Personal Representative Date

THIS FORM MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD ON TOP OF THE NOTICE OF ADDITIONAL PRIVACY PROTECTIONS REQUEST REVIEW FORM.