SUNY DOWNSTATE Medical Center

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 Medical Center

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

_____

_____

_____

_____

TERMINATION: The patient's request for restriction is being terminated. Document reason (if any):

_____

_____

_____

_____

- ❑ Patient agrees to modification/ termination.

  _____ _____
  Signature of Patient or Personal Representative Date

- ❑ Patient orally agrees to modification/ termination.

  _____ _____
  Signature of SUNY Downstate Member Date

- ❑ Patient does not agree to modification/ termination.
  Modification/ Termination is only applicable after patient notification date of ___/___/___.

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