SUNY DOWNSTATE Medical Center

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.