SUNY DOWNSTATE Medical Center

REQUESTS FOR ADDITIONAL PRIVACY PROTECTION

Patient Name: _____
Last Name First Name MI

Address: _____ Telephone:

_____ _____ (daytime)

_____ _____ (evening)

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 Medical Center 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 Medical Center 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