UNIVERSITY PHYSICIANS
BROOKLYN, INC.

FACILITY DIRECTORY FORM

This form must be completed when a patient has expressed an objection to the way we would ordinarily use or disclose his or her information in our facility directory. Completed form should be filed in the patient's medical record.

Patient Name: _____ **MR#:** _____

OBJECTION/ RESTRICTION

The following section should be completed if recording a new objection or restriction.

What information may not be disclosed?
__ Patient Name
__ Location in Facility: Room #, Telephone #
__ General Condition: Good, Fair, Serious, Critical
__ Religious Affiliation

To whom may the information not be disclosed?
__ Family Members, Specify _____
__ Clergy, Specify _____
__ General External Requestors, Specify _____
__ Other, Specify _____

For what period of time may the information not be disclosed?
__ Current visit
__ All future visits
__ Other, Specify _____

REVOCATION/ CLARIFICATION

The following section should be completed if revoking or clarifying objections or restrictions already in place.

What information may be disclosed (if changed)?
__ Patient Name
__ Location in Facility: Room #, Telephone #
__ General Condition: Good, Fair, Serious, Critical
__ Religious Affiliation

To whom may the information be disclosed (if changed)?
__ Family Members, Specify _____
__ Clergy, Specify _____
__ General External Requestors, Specify _____
__ Other, Specify _____

For what period of time may the information be disclosed (if changed)?
__ Current visit
__ All future visits
__ Other, Specify _____

_____	_____	_____
NAME OF STAFF MEMBER	SIGNATURE OF STAFF MEMBER	DATE