



**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. University Physicians of Brooklyn, Inc. 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 University Physicians of Brooklyn, Inc. 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