

### NOTICE OF ADDITIONAL PRIVACY PROTECTION REQUEST REVIEW

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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) 270-8105 if you have questions or concerns.

**A COPY OF THIS NOTICE MUST BE PLACED IN THE PATIENT’S MEDICAL RECORD**