STONY BROOK UNIVERSITY HOSPITAL
PATIENT REQUEST FOR RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)

You have the right to request that we restrict the use and disclosure of information for the purposes of this particular encounter at SBUMC. Please see our Notice of Privacy Practices for a more detailed description of your rights to request such a restriction of this information and the process we follow once we have received your request (bear in mind that in order to initiate/continue your treatment it may not be possible to grant your request). To request a restriction to your records, complete and return the following request form.

PATIENT INFORMATION

Patient Name: ____
Last First MI

Date of Birth: ________/___________/___________

Address:
____
____
____
____

Telephone:
____________________ (daytime)
____________________ (evening)

Email Address (optional):
____

RESTRICTION REQUEST

Please answer the following questions. You may attach a separate page if more space is needed.

What information would you like to restrict?

____
____
____
____
____
____

Who should the information be restricted from, and Why? Your request may be denied if you do not provide a reason to support your request.

____
____
____
____
____
____
____

PATIENT UNDERSTANDING AND SIGNATURE

By signing below, I am requesting that Stony Brook University Medical Center restrict my health information as I have explained above. I am aware that this request may be denied if SBUMC would not be able to initiate/continue my treatment, be paid for the service provided or continue normal operational functions without sharing the information I am requesting be restricted.

____
Signature of Patient or Personal Representative

____
Print Name of Patient or Personal Representative

____
Date

____
Description of Personal Representative's Authority

SEND COMPLETED FORM TO:

SBUMC HIM Dept.
Assistant Director of ROI
Stony Brook, NY 11794-7130

For [Medical Center] Use Only: **MR#** **ENC#**

Date Received: (MO/DY/YR) ____/____/____

Disposition of Request: ____ GRANTED ____ DENIED ____ PARTIALLY DENIED

Patient Notified In Writing On This Date: (MO/DY/YR) ____/____/____

Name of HIM Staff Member Processing This Request: ___________________________________