



PATIENT REQUEST FOR RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)

*You have the right to request that we restrict the use and disclosure of your protected health information (PHI) for certain purposes. Please see our Notice of Privacy Practices for a more detailed description of your rights to request such a restriction and the process we follow once we have received your request. To request a restriction on the use and disclosure of your PHI please complete and return this form. *Please note that if you are requesting a restriction on the disclosure of your PHI to a payer such as a health insurance company and you are paying for a service out of pocket, please complete form AD2N536. This form is not to be used for that purpose.*

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 PHI would you like to restrict the use or disclosure of? Please include what area of Stony Brook Medicine the PHI is from (e.g. name of hospital, name of physician practice).

What type of restriction are you requesting (e.g. who are you requesting the PHI be restricted from or what type of use of the PHI are you requesting a restriction on) and why?

PATIENT UNDERSTANDING AND SIGNATURE

By signing below, I am requesting that Stony Brook Medicine restrict my PHI as I have explained above. I am aware that this request may be denied if Stony Brook Medicine would not be able to initiate/continue my treatment, be paid for services provided or continue normal operational functions by adhering to my request.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Authority to sign on patient's behalf
(if applicable)

Date

SEND COMPLETED FORM TO:

Stony Brook Medicine Privacy Office
7 Flowerfield, Suite 36
St. James, NY 11780
Fax: 631-223-4310
Email: HIPAA@stonybrookmedicine.edu

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 Privacy Staff Member Processing This Request: