Stony Brook Medicine

## 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. 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 protected health information please complete and return this 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?**

_____
_____
_____
_____
_____
_____
_____

## PATIENT UNDERSTANDING AND SIGNATURE

By signing below, I am requesting that Stony Brook Medicine restrict my protected health information 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 be 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: _____