Patient Request to Restrict Uses and Disclosures of Protected Health Information

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") gives you the right to request restrictions on how NYU Langone Health uses and discloses your health information for treatment, payment, and health care operations or to family and friends involved in your care. For example, you can ask us not to use and/or disclose the results of a blood test or a certain condition to a specific person. NYU Langone Health is not required to agree to your restriction, except when your request is that we do not disclose your health information to a health plan if you have paid for the health care item or service out of pocket, in full. If we agree to your restriction, we will not use or disclose your health information in violation of the restriction, unless such use or disclosure is necessary for emergency treatment, is required or permitted by law, or the restriction has been properly terminated.

To request a restriction, please complete the form below and send to: Privacy Officer, NYU Langone Health, One Park Avenue, 3rd Floor, New York, NY 10016.

Patient Name (please print): _____ Date of Birth: _____

Patient Address: _____

Phone Number: _____ Email: _____

Describe the restriction that you are requesting NYU Langone Health to provide, including what information you would like to restrict and to whom the restriction will apply (for example, "Do not disclose information about my biopsy to my daughter Jane Doe")

_____

_____

_____

_____

I am requesting that NYU Langone Health provide the above described restriction of Protected Health Information. I understand that NYU Langone Health is not required to agree to this restriction.

Signature: _____ Date: _____ Time: _____ AM/PM
(Patient or person authorized to sign)

If the person consenting is not the patient, please print name and type of authority to sign.
Supporting documentation should be provided at the time of submission.

(08/19)