NYU Langone HEALTH SYSTEM

Patient Request to Restrict Disclosures of Protected Health Information to an Insurer

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") allows you to keep NYU Langone from sharing your Protected Health Information ("PHI") with your insurer when you pay for a health care item or service in full and out-of-pocket. We will honor this restriction on sharing your PHI, except when the disclosure of this information is required by law or the restriction has been properly ended.

You **must** fill out separate form for the hospital **and** each doctor you have seen at NYU Langone. This could be a surgeon, admitting physician, radiologist, pathologist, or any Faculty Group Practice physician.

Step 1: To be filled out by Patient Registration:

Explanation of Procedure/Service	Date of Service/Visit	Provider Name, Notes, Other Comments

Step 2: By signing this form, I understand that:

- I agree to pay all estimated costs today for the services listed above, based on the standard self-pay discounted rate. These costs are listed in the "Estimate of Charges" form given to me.
- I agree to pay the final bill in full when I get it.
- I do not meet the eligibility requirements for Financial Assistance under NYU Langone's Charity Care and Financial Assistance policy.
- Only records relating to the fully paid out-of-pocket services (whether they were paid by me or someone paid them for me but not by my insurer) will be kept from my insurer.
- If I don't make my payment(s), NYU Langone can bill and share the information with my insurer after reasonable efforts have been made to collect payment.
- If I don't pay and NYU Langone bills my insurance, those services may not be covered by my insurer if pre-authorization was not obtained. I understand I must pay the full amount not covered by my insurer.
- I agree that I will not submit any bills for the above services to my insurer.
- I am responsible for alerting or asking for limits on sharing PHI with all other providers not listed above.

I am asking that NYU Langone provide the above described limit the sharing of my Protected Health Information.

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.

Name/Authority: _____

Note: This form should be scanned into the patient's electronic medical record.

Office Use: Received: ____/_____/_____ Completed: ____/_____/_____ Initials: _____

(9/16)