



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 Medical Center 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 the Medical Center not to use and/or disclose the results of a blood test or a certain condition to a specific person. The Medical Center is not required to agree to your restriction, except when your request is that the Medical Center 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 Medical Center, One Park Avenue, 3rd Floor, New York, NY 10016.

Patient Name (print): _____

Patient Address _____

Phone Number: _____ Email: _____

Describe the restriction that you are requesting the Medical Center 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 Medical Center provide the above described restriction of Protected Health Information. I understand that the Medical Center is not required to agree to this restriction.

Signature: _____ **Date:** _____ **Time:** _____ **AM/PM**
(Patient or person authorized to sign)
If the consenting party is other than the patient, print name and relation to patient:

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