Patient Request for Restrictions on Uses and Disclosures of Protected Health Information

You have the right to request restrictions on the way we use and disclose your protected health information for treatment, payment, or health care operations. You may also request limitations on how we disclose information about you to family or friends involved in your care. We are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. If we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or to comply with the law. To request a restriction, please complete and return the form below.

PATIENT INFORMATION

Patient's Name: _____ Date of Birth: _____
Last First MI

Address: _____

Telephone: _____ _____
Daytime Evening

Email Address (Optional): _____

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RESTRICTION REQUESTED

Please answer the following questions. You may attach a separate page if more space is needed.

What information do you want to restrict? (Please include dates of treatment if possible.)

Do you want to limit how we use the information, how we disclose it to others, or both?

When should these restrictions apply? For example, you may request that we not disclose the restricted information to specific persons, such as your spouse.

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PATIENT UNDERSTANDING AND SIGNATURE

By signing below, I am requesting that Hospital for Special Surgery apply the above restriction to the way it uses and discloses my protected health information. I understand that Hospital for Special Surgery is not required to agree to my restriction, but if it does, it will be bound by its agreement.

_____

Signature of Patient or Personal Representative

_____

Print Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

SEND COMPLETED FORM TO:

Health Information Management
Hospital for Special Surgery
535 East 70th Street
New York, NY 10021

Or

Email to: ROIrequest@hss.edu

Or

Fax to 212-774-7364

FOR HOSPITAL FOR SPECIAL SURGERY USE ONLY:

Date Received: (MM/DD/YYYY) _____ / _____ / _____

Disposition of Request: ☐ Granted ☐ Denied ☐ Partially Denied

Patient Notified In Writing On This Date: (MM/DD/YYYY) _____ / _____ / _____

Name of Privacy Officer Processing This Request: _____