GLP-Western New York Urology Associates/Cancer Care of WNY (WNYUA/CCWNY)
PATIENT'S REQUEST TO RESTRICT USE
OR DISCLOSURE OF HEALTH INFORMATION PG 1

Last Updated: 6/2017

Name of Patient: _____

I request a restriction on the following concerning my Protected Health Information as described below:

- ☐ use
- ☐ disclosure, or
- ☐ both the use and disclosure

1. The Protected Health Information that I would like to have restricted is:

_____

_____

_____

2. I would like WNYUA/CCWNY to restrict the use and/or disclosure of the health information described above as follows: (e.g., "do not disclose this information to my son Joe"). I understand that I may request restrictions on (1) WNYUA/CCWNY's uses or disclosures of my Protected Health Information related to treatment, payment or health care operations; or (2) disclosures to my family or other persons involved in my care.

_____

_____

_____

I understand that if WNYUA/CCWNY agrees to my request to restrict use or disclosure of information, WNYUA/CCWNY must honor my request except when my records are released in connection with a use or disclosure of information that is: (i) necessary to provide me with emergency treatment; or (ii) required by law.

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PATIENT'S REQUEST TO RESTRICT USE
OR DISCLOSURE OF HEALTH INFORMATION PG 2

Last Updated: 6/2017

SIGNATURE

I have read, understand and had an opportunity to ask questions about this Request.

Signature of Patient or Personal Representative:_____

Print Name of Patient or Personal Representative:_____

Description of Personal Representative's Authority:_____

Date:_____

CONTACT INFORMATION

Contact information of the personal representative who signed this form:

Address:_____
_____
_____

Telephone: _____(Daytime) _____(Evening)

For Physician Use Only

Date WNYUA/CCWNY Received Request:_____

WNYUA/CCWNY's Decision on Request:_____ Accepted
_____ Denied

If Accepted, Action Taken by WNYUA/CCWNY:_____

Date Patient Notified of Decision:_____

Name and Title of Person Handling this Request:_____