COLUMBIA UNIVERSITY MEDICAL CENTER

Health Insurance Portability and Accountability Act (HIPAA)
HIPAA Compliance/Columbia University Medical Center
630 West 168th Street, Box 159
New York, NY 10032/ T(212) 342-0059 F(212)342-5173
http://www.cumc.columbia.edu/hipaa/

Effective Date: April 14, 2003

Request for Restrictions on Uses and Disclosures of Health Information

You may request a restriction on the use and disclosure of your health information for treatment, payment and administrative activities. HOWEVER WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST. NO RESTRICTION IS EFFECTIVE UNTIL YOU RECEIVE WRITTEN CONFIRMATION FROM THE COLUMBIA UNIVERSITY MEDICAL CENTER PRIVACY OFFICER. To submit a request, you must complete this form and return it to: **Privacy Officer, Columbia University Medical Center, 630 West 168th Street, Box 159, New York, N.Y. 10032.** This request applies only to the health disclosure of information for more than one office, you must complete a separate form for each office. **IN EMERGENCY TREATMENT SITUATIONS RESTRICTION AGREEMENTS WILL NOT APPLY.**

Please provide the following information:

Patient Name: _____ Date of Birth: _____

Phone Number: _____

Address: _____

Please specify the health care provider office from which you are requesting a restriction

_____

Please describe the information to which this request applies (*e.g.*, pregnancy test results).

_____
_____
_____

Please describe how you would like the use and/or disclosure of your health information restricted.

_____
_____
_____
_____
_____

_____ _____
Signature of patient or personal representative Date

_____
If personal representative, authority to act on behalf of patient

For Columbia University Medical Center use only:

□ Grant request □ Deny request

Agreement terminated/agreed to by: Patient Columbia University Medical Center Termination date, if applicable:

Documentation of oral termination by patient: