Office of HIPAA Compliance
630 West 168th Street, Box 159
New York, NY 10032
Tel: (212)342-0059 Fax: (212) 342-5173
HIPAA@cumc.columbia.edu

Restriction for Use and Disclosure of Patient Information

Patient Name: _____ **Date of Birth:**_____

Phone Number: _____

To submit a request, complete this form and return it to the provider's office or program listed below.

- To request that a provider program communicate with you by an alternative method, e.g., cell phone only or by location (send mail to work address)
- To request restrictions on a use (health information with other doctors, nurses or clinics) or a disclosure of health information (e.g., to a law firm)
- All requests must be received in writing
- COLUMBIA IS NOT REQUIRED TOAGREE TO THIS REQUEST; however, if agreed, every effort will be made to comply with such requests.
- A RESTRICTION REQUEST IS NOT EFFECTIVE UNTIL YOU RECEIVE WRITTEN CONFIRMATION FROM COLUMBIA UNIVERSITY.
- **NOTE THAT RESTRICTION AGREEMENTS DO NOT APPLY IN AN EMERGENCY.**

Specify the provider's office/program which you are requesting a restriction

_____

Describe the information to which this request applies

_____

_____

_____

Please describe the restriction

_____

_____

_____

_____ _____

Signature of patient **Date**

For Columbia University Medical Center use only: □ Approve request □ Deny request

Forward request to the Office of HIPAA Compliance

Revised: July 2017