Northwell Health℠
North Shore-LIJ Health System is now **Northwell Health**

Appendix 1

REQUEST FOR CONFIDENTIAL COMMUNICATIONS AND/OR RESTRICTIONS ON ACCESS, USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby request that my Protected Health Information be confidentially communicated and/or restricted as described below. I understand that this request will apply to all future communications after the date listed below.

I understand that this request only applies to the North Shore-LIJ Health System. Any other request for confidential communication or other restriction from any other health care provider must be made by contacting that health care provider directly. I understand that I should resubmit this request whenever I visit a new North Shore-LIJ practice or facility.

Finally, I understand that if I do not respond in a timely manner to correspondence sent to the requested alternate address, correspondence is returned undeliverable to the requested alternate address, or the requested alternate phone is disconnected or out of service, the North Shore-LIJ Health System will communicate with me via other means and/or at other locations.

PATIENT NAME (PRINT): _____ **DATE OF BIRTH:** _____

Location(s) Where Patient Receives Medical Treatment: _____

Please be advised that you should submit an additional form if you seek treatment at a North Shore-LIJ site that you have not listed on this form.

☐ **RESTRICTION ON USE, ACCESS or DISCLOSURE REQUESTED:**

Description of requested restriction, if applicable (including person/entity and content of Protected Health Information that is to be restricted, such as date of service, type of treatment or other health care services):

_____

_____

☐ **CONFIDENTIAL COMMUNICATION REQUESTED – PLEASE USE ALTERNATIVE CONTACT INFORMATION BELOW:**

Street Address: _____

Suite/Apt. Number (if applicable): _____ City: _____

State: _____ Zip Code_____ Phone Number: _____

_____ **Date / Time:** _____

Signature of Patient or Personal representative

_____

Personal Representative's relationship to Patient

_____

Telephonic Interpreter's ID #

OR

_____ _____

Signature: Interpreter **Print: Interpreter's Name and Relationship to Patient**

This form should be submitted to the following:

Office of Corporate Compliance
North Shore-Long Island Jewish Health System
200 Community Drive
Great Neck, New York 11021
Telephone: 516.465.8097
Fax: 516.465.8996

FACILITY USE ONLY:

Patient Med Record Number: _____ Patient Acct Number: _____

Patient Date of Admission: _____

System updated to reflect alternate information by: _____

SIGNATURE DATE

Copy 1 – Patient Medical Record **Copy 2** – Admitting **Copy 3** – Patient or Patient's Personal Representative