North Carolina A & T State University

Sebastian Health Center

REQUEST FOR ADDITIONAL PRIVACY PROTECTION

The Health Information Portability and Accountability Act of 1996 (HIPAA) provides that you have two specific rights to request additional privacy protections for your health information:

A. **Request for alternative communication methods:** You have the right to request that we communicate with you in ways and to locations other than our normal operating procedure. We will accommodate any reasonable request. So that we are sure that we understand your request, we require that it be in writing. Please describe your request below (and be sure to be specific about the alternative contact mailing address or telephone numbers, if any):

I _____ request that you communicate with me as follows:
(print name)

_____

_____

_____

_____

Patient/Legal Representative Signature: _____

ID# _____ Date of Birth: _____ Date of Request: _____

Form of ID presented for verification: _____ Witnessed by (SHC Staff) _____

B. **Request for additional restrictions on use and disclosure:** You have been given our Notice of Privacy Practices that describe how we use, disclose and protect your health information. You also have the right to request that we limit those uses and disclosures. As described in the Notice of Privacy, we may, but are not required to agree to these restrictions, but your concern and request is important to us. Please describe below any additional restrictions you would like us to agree to:

_____

_____

_____

_____

_____

Patient/Legal Representative Signature: _____

ID# _____ Date of Birth: _____ Date of Request: _____

Form of ID presented for verification: _____ Witnessed by (SHC Staff) _____

SHC USE ONLY

Request Status (circle one): Accepted Denied Date:_____ Time:_____

NCATSU SHC Representative Signature _____

Date Notification Sent _____

C. **Request for termination of restriction or confidential communications:** You may terminate this agreement at any time by written request or documented oral agreement. The SHC may terminate this agreement at any time with written notification. Any protected health information created or received before termination will remain restricted.

Please terminate my request for restrictions or confidential communications as described on page one of this form.

Patient/Legal Representative Signature: _____

ID# _____ Date of Birth: _____ Date of Request: _____

Form of ID presented for verification: _____ Witnessed by (SHC Staff) _____

Termination of restrictions or confidential communications request by the Student Health Center

Date of termination _____ Date Notification Sent _____

Terminated by (SHC Staff Signature) _____