Catholic Health

REQUEST FOR ADDITIONAL PRIVACY PROTECTIONS

Amendment - SCAN, REQ FOR ADDITIONAL PRIV PROTECT, 8/13/24

Date: _____

Patient Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Important Information: *By completing this form you are requesting that additional privacy protections be placed on your Protected Health Information.This request will only be honored after the receipt of such by Catholic Health. Catholic Health is not responsible for actions taken prior to receipt of your request. Protections may not apply in all situations, such as in an emergency, however Catholic Health will comply with the request(s) below in accordance with applicable law.*

*This request needs to be sent to each Catholic Health entity including hospitals, practices, programs and facilities where the request would apply.

Select the appropriate request below:

☐ **Request Restriction on Use, Access or Disclosure**

Provide a description of your request for restriction.(ex. Entity/Individual/Type of Information)

_____

_____

_____

☐ **Remove Restriction on Use, Access or Disclosure**

Date Signed (if known): _____

☐ **Request for Confidential Communications**

Please use alternate contact information below:

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: (_____) _____ ☐ cell ☐ home ☐ work

☐ **Revoke previous Authorization for Release of Health Information Pursuant to HIPAA**

Date Signed (if known): _____ *Original Disclosure to (person/entity):* _____

Patient or Personal Representative Name:

_____ _____

Print Signature

If Personal Representative, please complete the information below:

_____ _____

Relationship to Patient Contact Information (if different from above)

FOR CATHOLIC HEALTH USE ONLY

Date Request Received: _____

Name of Workforce Member Processing: _____

MRN: _____ CSN: _____

System/s Updated: _____ Facility/Entity: _____