REQUEST TO RESTRICT THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

You have the right to request that Erie County restrict the use or disclosure of certain Protected Health Information. Please refer to the Erie County Notice of Privacy Practices for a more detailed description of your rights. In some circumstances, Erie County is not required to agree with your request. If Erie County agrees to your request, we will comply with the request unless the information is needed to provide emergency treatment. To make a request, please complete and return this form to:

Erie County Chief Privacy Officer
95 Franklin Street, Room 1634
Buffalo, NY 14202
Chief.Privacy.Officer@erie.gov

CONTACT INFORMATION

PATIENT NAME: _____
(please print)

PHONE NO.: _____

DATE OF BIRTH: _____

MAILING ADDRESS: _____

EMAIL: _____ DATE OF REQUEST: _____

DESCRIPTION OF REQUEST

1. Please indicate which of the following department(s) of Erie County you would like to restrict the use or disclosure of Protected Health Information:

- ☐ Department of Emergency Services
- ☐ Department of Health
- ☐ Department of Mental Health
- ☐ Other _____
- ☐ Department of Senior Services
- ☐ Department of Social Services
- ☐ Youth Services

2. Please describe your request to restrict the use and/or disclosure of Protected Health Information in the space below.

_____

_____

_____

3. Please provide the names of any family members, relatives or other persons to whom you do not want Erie County to disclose information in the space below.

_____

_____

_____

SIGNATURE

I have read, understand and had the opportunity to ask questions about this request. I further understand that under some circumstances, Erie County may deny this request.

SIGNATURE: _____ DATE: _____

NAME AND ADDRESS OF PERSONAL REPRESENTATIVE (if applicable):

_____

PERSONAL REPRESENTATIVE'S AUTHORITY (supporting documentation is required):

- ☐ Parent
- ☐ Court-Appointed Guardian
- ☐ Health Care Agent
- ☐ Power of Attorney
- ☐ Administrator/Executor
- ☐ Other: _____

VERIFICATION REQUIREMENTS

For in-person requests for an amendment of health information, patients and authorized representatives can meet verification requirements with one of the following:

☐ In-person patient request verified by government-issued photo identification (copy of ID to be retained with request)
☐ In-person request by authorized third party - parent, legal guardian, or other court-appointed representative verified by government issued photo ID *and* copy of appointing document (copy to be retained with request)

Notarization is required for requests submitted to Erie County by mail. An authorized representative must also submit a copy of the appointing document. The notary public or other officer authorized to take and certify acknowledgments and administer oaths must complete the following:

STATE OF NEW YORK

COUNTY OF _____

On the _____ day of _____ in the year _____ before me, the individual referenced above, personally appeared and proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this form and acknowledged to me that he or she executed the same in his or her capacity, and that by his or her signature(s) on the form, the individual executed the form.

_____
Notary Public

Printed Name: _____ My Commission Expires: _____