Request to Exercise Privacy Rights

Date _____ Medical Record Number _____ Date of birth _____

Patient name _____ Phone number _____

Street address _____

City _____ State _____ Zip Code _____

This form lets you exercise the privacy rights that you have under federal law. **You have the right to ask us:**

- ☐ **To contact you privately to discuss your health information**
- ☐ **To change information that you think is wrong**
- ☐ **To limit the release of your information to others**
- ☐ **For a list of people and places that we have sent your information**

Instructions:

1. Please check the box(es) above for the request(s) you are making
2. Please tell us the details below such as:
   a. How or where to contact you (example: at work, by fax or by mail);
   b. Information that you think is wrong in your chart;
   c. To whom you do not want your information given and/or what information to restrict;
   d. Dates of visits that are affected by your request; and
   e. Which Novant facility(ies) are involved.

Contact Novant Health Privacy Office at 800-473-6610 extension 49829 if you have any questions.

_____

_____

_____

_____

Patient signature _____ Date/time _____ Legal Representative/relationship _____ Date/time _____

Witness signature _____ Date/time _____

For Office Use Only

☐ Request granted ☐ Request granted in part. (Explain) _____

☐ Request denied (Explain) _____

Supervisor/Manager/Designee signature-title _____ Date/time _____

☐ Restrictions ended, effective immediately

Supervisor/Manager/Designee signature-title _____ Date/time _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter accepted _____ ☐ Interpreter refused

(Name/number of person/services chosen/used)

NOVANT HEALTH

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Name / MR # / Label