

**ST. JOHN'S EPISCOPAL HOSPITAL, SOUTH SHORE  
PATIENT OBJECTION TO  
USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR  
CERTAIN PURPOSES**

<b>Patient's Name:</b>	_____
	Last <span style="margin-left: 150px;">First</span> <span style="margin-left: 150px;">Middle</span>
<b>Home Address:</b>	_____
	_____
<b>Home Telephone:</b>	_____
<b>Date of Birth:</b>	_____

**TYPES OF USE AND DISCLOSURE**

1. Patient Directory. Use of the following pieces of Protected Health information about me to maintain a directory of individuals at St. John's Episcopal Hospital and disclosure of such information for directory purposes to members of the clergy and persons who ask for me by name.
  - a. my name;
  - b. my location in the Hospital
  - c. my condition described in general terms that do not communicate specific medical information; AND
  - d. my religious affiliation (which information may only be disclosed to members of the clergy).
  
2. For Involvement of Others in My Care. Disclosure of my Protected Health Information to a family member, other relative, close personal friend, or any other person identified by me, that is directly relevant to that person's involvement with my care or payment for my care.
  
3. For Notification of My Location, General Condition or Death. Disclosure of my Protected Health Information to notify (or assist in the notification of) my family member (or personal representative or other person responsible for my care) of my location, general condition or death.
  
4. For Disaster Relief Efforts. Disclosure of my Protected Health Information to a public or private entity authorized to assist in disaster relief efforts in order to coordinate efforts to notify (or assisting in the notification of) my family member (or personal representative or other person responsible for my care) of my location, general condition or death.

I hereby request that the Hospital restrict the use and disclosure of my Protected Health Information. By my signature below, I hereby request that a restriction of the use and disclosure of my protected Health Information be placed on the following:

*(please see next page)*

Please check one of the boxes below:

- The use and disclosure of my health information for all of the four purposes described above.
- The use and disclosure of my health information only for the following purposes:  
**Please circle the applicable purpose(s):**  
**1 Patient Directory**                      **2 Involvement of Others in My Care**  
**3 Notification of My Caregiver**      **4 Disaster Relief Efforts**
- the use and disclosure of my health information for all of the four purposes described above, subject to the following restriction(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.
- By my signature below, I hereby prohibit the use and disclosure of my health information for all of the above listed purposes.

\_\_\_\_\_  
Signature of Patient (or Personal Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Personal Representative

\_\_\_\_\_  
Relationship to Patient