

RIGHT TO REQUEST RESTRICTIONS ON USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION POLICY AND PROCEDURE

PURPOSE

To ensure that _____ (the "Facility") and any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility ("Associates") to comply with applicable laws that grant residents or a resident's legal representative (collectively referred to herein as the "resident") the right to request restrictions on the use or disclosure of their protected health information (PHI).

POLICY

- I. It is the policy of the Facility that residents have the right to request that otherwise permitted uses and disclosures of PHI be restricted. Specifically, residents may request restrictions on:
 - A. The use and disclosure of PHI for treatment, payment, or health care operations, or
 - B. The disclosures to family, friends, or others for involvement in care and notification purposes.
- II. The Facility is not required to comply with such requests for restriction, but will consider and may agree to a restriction. The Facility will consider the need for access to PHI for treatment purposes when considering a request for a restriction.
- III. Where the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law or the PHI pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full, the Facility must agree to the restriction.

PROCEDURE

- I. Request for Restriction on Use or Disclosure:
 - A. All requests for the restriction of PHI must be made in writing. If a resident submits a written request for restrictions, the Compliance and Ethics Officer will determine whether the request is adequate based on the information provided.
 - B. A request for restriction will not be reviewed until the Request to Restrict form is completed and signed by the resident. The Compliance and Ethics Officer may assist the resident in

completing the form, if necessary.

- C. The Compliance and Ethics Officer will review the request in consultation with the other Facility staff to determine the feasibility of the request. The Facility shall give primary consideration to the need for access to the PHI for treatment and payment purposes in making its determination.
- II. Responding to Request for Restriction on Use or Disclosure: The Compliance and Ethics Officer shall determine whether a request for restriction on use or disclosure should be accepted or denied for reasons acceptable under State and Federal law and inform the resident in writing of the determination.
- III. Restriction on Use or Disclosure Not Accepted:
 - A. If the Facility declines the request for restriction, the Compliance and Ethics Officer will provide the resident with a copy of the signed response.
- IV. Restriction on Use or Disclosure Accepted:
 - A. If the Facility agrees to the requested restriction, the Facility must abide by the restriction, except:
 - a. The Facility may use the restricted PHI, or may disclose such information to a health care provider if:
 - i. The resident is in need of emergency treatment, and
 - ii. The restricted PHI is needed to provide emergency treatment. In this case, the Facility will release the information, but ask the emergency treatment provider not to further use or disclose the resident's PHI.
 - b. The Facility may disclose the information to the individual who requested the restriction.
 - c. The Facility may use and disclose the restricted PHI when statutorily required to use and disclose the information under the HIPAA Privacy Rule.
 - B. The Compliance and Ethics Officer will notify appropriate the Facility staff of the restriction.
 - C. Written Notice. If the Compliance and Ethics Officer determines that the Facility will grant the request for a restriction on use or disclosure, in whole or in part, the Facility will complete and send the resident a written notice of agreed upon restriction.
 - D. Informing Others of Request for Restriction on Use or Disclosure. In the event restricted PHI is used or disclosed to a health care provider for emergency treatment, the Facility must request that such health care provider not further use or disclose the PHI.
 - E. Certain Circumstances in Which Requests Will Be Granted. Among

other circumstances that may form the basis for a request to be granted, the Facility will grant the request for a restriction on use or disclosure if:

- a. except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and
- b. The protected health information pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.

V. Restriction on Use or Disclosure Denied:

- A. Written Notice. If the Compliance and Ethics Officer denies the resident's request for a restriction on use or disclosure, in whole or in part, the Facility will provide the resident with a written notice of restriction denial.

VI. Termination of an Agreed to Restriction:

- A. The Facility may terminate its agreement to a restriction or the resident may seek to have the restriction terminated if:
 - a. The resident agrees to or requests the termination in writing; or
 - b. The resident agrees to the termination verbally and the verbal agreement is documented.
 - c. The covered entity informs the individual that it is terminating its agreement to a restriction, except that such termination is:
- B. Not effective for protected health information that the Facility must agree to requested restrict by law
- C. Only effective with respect to protected health information created or received after it has so informed the individual.

VII. Documentation of Restriction: As required by law the Facility will document a restriction, a copy of which will be placed in the resident's file.

REQUEST TO RESTRICT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Resident Name: _____

Medical Record No: _____

Address: _____

Directory Information Restriction: I request that the disclosure of my information maintained in the Facility directory be restricted in the following manner:

_____ Do not include my name, location, general condition or religious affiliation in the Facility directory.

_____ Do not disclose my name or religious affiliation to members of the clergy.

_____ Do not disclose my location in the building to: _____.

_____ Do not disclose my general condition to: _____

Signature of Resident or Personal Representative

Date

Print Name

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

Other Restrictions: I request the following restriction(s) on the use or disclosure of my Protected Health Information:

_____ Do not release information to the following person(s)

Other restriction (please specify):

Signature of Resident or Personal Representative

Date

Print Name

Personal Representative
Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

THE FACILITY RESPONSE:

____ Your request for restriction has been declined.

Note: The Facility may not deny a request for restriction of Directory Information.

____ Your request for restriction has been accepted. In the case of an emergency or if necessary to comply with the law, we may use and disclose your health information in violation of the restriction. Other than in those circumstances, we will abide by your request unless and until the restriction is terminated (with or without your agreement) and you are notified.

Signature of the Facility Privacy Official
Date

Print Name

TERMINATION OF RESTRICTION

____ The above-named resident agreed to terminate this restriction on: _____.

____ The above-named resident was notified on _____ (date) that this restriction was terminated.

- Resident was notified: (check appropriate box)

____ In person

____ By telephone (attach documentation of notification)

____ By mail (attach documentation of notification)

Signature of the Facility Privacy Official
Date

Print Name

Distribution of copies: Original to resident's Medical Record; copy to resident.