

**Silverton Health
GENERAL MANUAL**

**TITLE: PHI - PATIENTS RIGHT TO REQUEST PRIVACY
RESTRICTIONS**

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Policy No: GEN-IM-1717**

Date Issued: November 2010

Date Reviewed:

Date Revised: December 2013

Author: Privacy Officer, Security
Officer

Source/Reference: Health Insurance Portability and Accountability Act (HIPPA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, Health Information Technology for Economic and Clinical Health Act (HITECH) component of the American Recovery and Reinvestment Act (ARRA) of 2009

Departments Affected: All

PURPOSE: To ensure the patients right to request privacy restrictions on the use or disclosure of their Protected Health Information (PHI) as required by the Health Insurance Portability and Accountability Act (HIPPA), the Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, the Health Information Technology for Economic and Clinical Health Act (HITECH) component of the American Recovery and Reinvestment Act (ARRA) of 2009, and any and all other Federal regulations and interpretive guidelines promulgated there under.

POLICY STATEMENT: Patients have the right to request restriction of certain uses and disclosures of their PHI that is contained within the designated record set including restricting disclosures to their health plan. Exceptions may include psychotherapy notes, information compiled for use in civil, criminal or administrative actions, and information that is subject to prohibition by the Clinical Laboratory Improvements Amendments (CLIA). Requests for such restrictions must be made in writing to the Silverton Health Privacy Officer (SPO) or designee. For patient requests to restrict disclosure to their health plan they must fill out the Do Not Bill Insurance Restriction Request form and the visit must be paid in full before Silverton Health can to honor the request. A determination to restrict other uses or disclosures must be made very carefully to ensure the request can be met. Unless otherwise indicated below, Silverton Health (SH) may deny a request under certain circumstances.

Required Disclosure Restriction: SH must comply with a patient's request to restrict or limit the disclosure of the individual's protected health information (PHI) if 1) (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** 2) the PHI pertains solely to a health care item or service for which the patient (or patient representative) has paid Silverton Health in full.

Emergency Treatment Exception: If SH agrees to a restriction, the HIPPA privacy regulations provide an exception in emergency treatment situations for a hospital or provider to use and disclose necessary information to treat the patient.

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PROCEDURE:

Requests for Restrictions and Timely Action:

1. SH must permit a patient to request restrictions on the use and disclosure of PHI as contained in the designated record set. Requests for restrictions must be presented in writing (see attached sample restriction request form).
2. The written request must be routed to the SPO. PAS, billing, and the SPO will work together to honor restriction requests for health plans. The SPO will work with whomever she/he deems necessary to determine other restriction requests.
3. The right to request restrictions and SPO contact information shall outlined in the Notice of Privacy Practices.
4. Unless otherwise required by law, SH must agree to a patient's requests for restrictions or limitations for disclosures to the patient's health plan for payment or health care operations purposes if the patient (or patient representative) has paid in full for the health care item or service and the PHI pertains solely to that item or service.
5. For requests that are not required restrictions, SH is not required to act immediately and will investigate its ability to meet the request prior to agreeing to the restriction.
6. The patient's request and the letter notifying the patient of the SPO's decision will be filed with the designated record set.

Providing the Restriction: Unless the request cannot be denied by law, the SPO must ensure that the request can be met and that the designated record set is flagged per facility procedure.

Denial of Request:

1. Except as otherwise required by law, SH may not deny a patient's request for restrictions or limitations for disclosures to the patient's health plan for payment or health care operations purposes if the patient has paid in full for the health care item or service and the PHI pertains solely to that item of service.
2. SH may deny any other request that is not a required restriction.
3. The patient must be notified of the denial by the SPO in writing (see attached sample denial letter).

Required Documentation:

1. SH must document the following:
 - a. The designated record sets that are subject to restriction; and
 - b. The titles of the persons or offices responsible for receiving and processing requests for access by individuals.
2. All correspondence and associated documentation related to patient requests for restrictions, including denials, must be maintained and retained per the Records Retention policy (GEN-IM-144) or six (6) years, whichever is longer.

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Terminating a Restriction: SH may terminate its agreement to a restriction if the following occurs.

1. The individual agrees to request the termination in writing;
2. The individual orally agrees to the termination and the oral agreement is documented;
3. The patient or patient representative has not paid in full for the service that the health plan restriction is requested for; or
4. SH informs the individual that it is terminating its agreement to a restriction, except that such termination is only effective with respect to protected health information created or received after it has so informed the individual.

Note: Restrictions may not be terminated without the patient's permission for disclosures to the patient's health plan for payment or health care operations purposes if the patient (or patient representative) has paid in full for the health care item or service and the PHI pertains solely to that item or service.

Request of Health Plan Restriction: If a patient requests a health plan restriction at time of registration or within four (4) days from the time of service and has paid in full for the service:

1. PAS will have the patient fill out the Do Not Bill Insurance Restriction Request form.
2. PAS will scan a copy of the form into the patient record. The patient will receive a copy of the form and the original will be routed via inter-office mail to the SPO.
3. PAS will change the patient's insurance information for that visit to insurance type "Do Not Bill".
4. PAS will mark the visit as "Confidential."
5. Once in receipt of the Do Not Bill form, the SPO will seal the record in Meditech thus limiting access, will inform other departments via e-mail that may be affected, and will review any records requests for the specific service to determine if SH is able to fulfill the request (such as request for continuity of care purposes).
6. Billing will not process bills for patients whose accounts are paid in full and have an insurance of "do not bill."

It is not the responsibility of SH to inform "down-stream" providers of the patients request to restrict disclosures to their health plan. The patient must make the request of any provider they do not want disclosing their PHI.

All other restriction requests will be determined after review on a case by case basis.

Approvals: Policy Review Team 12/13/13

Related Policies:

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APPENDIX A: Sample Denial of Request for Restriction

Patient Name:

Date of Birth:

Patient Medical Record Number:

Dear (patient):

At Silverton Health each patient is provided the right to request restrictions on uses and/or disclosures of his or her protected health information. Each request is reviewed subject to the limitation outlined in the HIPAA Federal Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164).

Reason for denial of requests (check that apply):

- Based on our system and process requirements we are unable to make the restriction you requested.
- The request was not made in writing.
- The request was not made to the Silverton Health Privacy Officer or designee per the Notice of Privacy Practices and Policy.

You may request a review of this denial by contacting the Silverton Privacy Officer. The request must be made in writing.

Emergency Treatment Exception: If Silverton Health agrees to a restriction request or a portion thereof, HIPAA privacy regulations provide an exception in emergency treatment situations for a hospital or provider to use and disclose necessary information to treat the patient.

Please contact me with any questions or concerns you might have.

Silverton Privacy Officer / Health Information Management

Phone: (503) 873-1527

Address: Silverton Health
342 Fairview St
Silverton, OR 97381

Cc: (Attending Physician)

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APPENDIX B: Privacy Restrictions Request Form

Please complete the following information:

Today's Date: _____

Patient Full Legal Name: _____

Patient Street Address: _____

City, State and Zip: _____

Patient Birth Date: _____

Date associated with information to be restricted (e.g., date of office visit, treatment, or other health care services). _____

Describe the information to be restricted (e.g., lab test results, physician notes).

What is your reason for making this request? (Optional)

I understand if I am currently enrolled in an active health care insurance plan, that the coverage for related services may be impacted.

Signature of patient/legal representative: _____

Forward to:

*Silverton Privacy Officer / Health Information Management
Phone: (503) 873-1527
Address: Silverton Health
342 Fairview Street
Silverton, OR 97381*



PAS.INS.REST

DO NOT BILL INSURANCE RESTRICTION REQUEST

Name (Last, First, MI): _____
 Other Name(s) Used: _____ Date of Birth: _____
 Street Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone: _____

I am requesting restriction of disclosure on records for the following visit(s):
 Date of Service: _____ Type of Visit: _____

I hereby request that Silverton Health not disclose my Protected Health Information, including treatment, payment, or health care operations, regarding the listed service date to the health plan(s) described below:

For the date of: _____
 Health Plan(s): _____
 Information pertaining to: _____
 I understand that my visit must be paid in full before Silverton Health can honor my request.

Signature: _____ Date: _____
Signature of Patient or Personal Representative

If personal representative signed the request on behalf of the patient, complete the following:

Print Name: _____
 Relationship to Patient: Power of Attorney* Legal Guardian*
 Parent Other: _____

*Attach legal documentation if you are the Legal Guardian or Power of Attorney for Health Care

For Internal Use Only

Date Received _____ Initials _____ MRN _____
 Sent To _____ Date _____

 **Silverton Health**
 Insurance Restriction Request

PATIENT IDENTIFICATION LABEL