**PURPOSE**

To provide a process for a patient to request a restriction to an otherwise permitted use or disclosure of the patient’s Protected Health Information (“PHI”), and for [COVERED ENTITY] to respond to such request.

**POLICY**

[COVERED ENTITY] recognizes a patient’s right to request that it restrict its use or disclosure of the patient’s PHI in certain situations as described below.

[COVERED ENTITY] will consider all requests for restrictions, however, it has no obligation, except in the limited circumstances described below, to agree to any such request, nor must it cite a reason for refusing to agree to any such request.

[COVERED ENTITY] recognizes that patients have a right to request restrictions on the use and disclosure of their PHI in the following circumstances:

* To carry out treatment, payment, or health care operations;
* To the patient’s family member, other relative, close personal friend, or any other persons who might otherwise receive disclosures of Protected Health Information where directly relevant to such person’s involvement with the patient’s health care or to payment related to the patient’s health care;
* To notify, or assist in the notification of (including identifying or locating), a patient’s family member, personal representative or other person responsible for the patient’s health care, about the patient’s location, general condition or death;
* To make reasonable determinations regarding limited uses and disclosures when the individual is not present;
* To public or private entities authorized to assist in disaster relief efforts, in order to notify or assist in the notification of (including identifying or locating), a patient’s family member, personal representative or other person responsible for the patient’s health care, about the patient’s location, general condition or death.

**PROCEDURE**

1. Request for Restriction. [COVERED ENTITY]’s Notice of Privacy Practices Patients will notify patients of their right to request restrictions on the use and disclosure of PHI and that any such requests must be in writing. The Privacy Official shall manage requests for restrictions. All documentation associated with this request will be placed in the patient’s Medical Record.
2. Response to Request. [COVERED ENTITY] **must**accommodate a request for restriction on disclosure if the disclosure (1) is to a health plan for purposes of carrying out payment or health care operations, (2) pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full, and (c) is not otherwise required by law.
	1. *Restriction Not Accepted*. If [COVERED ENTITY] denies the request for restriction, the Privacy Official will notify the patient in writing of its denial.
	2. *Restriction Accepted*. If [COVERED ENTITY] agrees to the requested restriction, it will notify the patient in writing when a request for restriction is accepted. [COVERED ENTITY] must abide by the accepted restriction with the following exceptions:
		1. [COVERED ENTITY] may use the restricted PHI, or may disclose such information to a health care provider if the patient is in need of emergency treatment, and the restricted PHI is needed to provide emergency treatment. In this case, [COVERED ENTITY] will release the information, but ask the emergency treatment provider not to further use or disclose the patient’s PHI.
		2. [COVERED ENTITY] may disclose the information to the individual who requested the restriction.
		3. [COVERED ENTITY] may use and disclose the restricted PHI when statutorily required to use and disclose the information under the HIPAA Privacy Rule.
	3. Any agreed-to restriction should be maintained in the patient’s medical record and a copy should be provided to all relevant individuals who are or may be responsible for implementing the restriction. [COVERED ENTITY] will notify separately any business associates to which the restriction may apply.
3. Terminating the Restriction.
	1. *Termination with the patient’s agreement:* [COVERED ENTITY] may terminate the accepted restriction if the patient agrees to the termination in writing; or the patient agrees to the termination verbally and the verbal agreement is documented. The Privacy Official will notify the appropriate individuals and business associates of the termination of the restriction. The Privacy Official will document the patient’s agreement to the termination of the restriction and maintain the documentation in the patient’s record. Termination of a restriction with the patient’s agreement is effective for all PHI created or received by [COVERED ENTITY].
	2. *Termination without the patient’s agreement*: [COVERED ENTITY] may terminate the restriction without the patient’s agreement if it informs the patient that the restriction is being terminated. Such termination is only effective with respect to PHI created or received after [COVERED ENTITY] has informed the patient that it is terminating the restriction. [COVERED ENTITY] must continue to abide by the restriction with respect to any PHI created or received before it informed the patient of the termination of the restriction. Any termination of an agreement to a restriction by [COVERED ENTITY] should be made and confirmed in writing.

**REQUEST TO RESTRICT USE AND DISCLOSURE**

**OF PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medical Record No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Directory Information Restriction: I request that the disclosure of my information maintained in [COVERED ENTITY] directory be restricted in the following manner:

\_\_\_\_\_Do not include my name, location, general condition or religious affiliation in [COVERED ENTITY]’s 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 Patient 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 Patient or Personal Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Representative’s Title (e.g., Guardian, Executor of Estate,

Health Care Power of Attorney)

**REQUEST TO RESTRICT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION - side 2**

[COVERED ENTITY] RESPONSE:

\_\_\_\_\_Your request for restriction has been denied.

Note: [COVERED ENTITY] 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 Privacy Official Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

**TERMINATION OF RESTRICTION**

\_\_\_\_\_The above name patient agreed to terminate this restriction on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_The above named patient was notified on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date) that this restriction was terminated.

Patient was notified: (check appropriate box)

\_\_\_\_\_In person

\_\_\_\_\_By telephone (attach documentation of notification)

\_\_\_\_\_By mail (attach documentation of notification)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Privacy Official Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name