SUNY DOWNSTATE MEDICAL CENTER

UNIVERSITY HOSPITAL OF BROOKLYN
POLICY AND PROCEDURE

No. HIPAA-18

Subject: **PATIENT REQUESTS FOR ADDITIONAL PRIVACY PROTECTION**

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Original Issue Date 11/02

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Effective Date: 12/07

The JC Standards:

Issued by: Regulatory Affairs

I. PURPOSE

To establish a policy and procedure for allowing a patient to request additional privacy protections to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations.

II. POLICY

SUNY Downstate will ensure that patient requests for additional privacy protections in terms of restrictions on uses and disclosures of PHI and confidential communications are reviewed in a timely manner and will grant or deny the requests appropriately as required by State and Federal law, professional ethics and accreditation agencies.

III. DEFINITION(s)

None

IV. RESPONSIBILITY

It is the responsibility of all medical staff members and hospital staff members to comply with this policy. Medical staff members include physicians as well as allied health professionals. Hospital staff members include all employees, medical or other students, trainees, residents, interns, volunteers, consultants, contractors and subcontractors at the hospital.

V. PROCEDURE/GUIDELINES

All requests for restrictions and confidential communications must be referred to the Department of Patient Relations.

A. Restrictions on Uses & Disclosures of PHI- Patients have a right to request that SUNY Downstate restrict the way we use or disclose their PHI for treatment, payment or healthcare operation purposes.

1. Obtain Written Request- Patient should document the request. See attached Requests for Additional Privacy Protection form.
2. Evaluate the Request- Patient Relations representative, in conjunction with the appropriate department, should evaluate the request to determine whether it should be granted or denied. The following factors should be considered:
    a. Whether the restriction may cause SUNY Downstate to violate applicable federal or state law. Patient Relations should contact the Privacy Director and/or legal counsel for assistance.
    b. Whether the restriction may cause SUNY Downstate to violate professional standards, including medical ethical standards;
    c. Whether SUNY Downstate's information systems make it unfeasible to accommodate the request;
    d. Whether the restriction may unreasonably impede SUNY Downstate's ability to provide treatment to the patient;
    e. Whether the patient is prepared to make alternative payment arrangements if the restriction will impede the ability of an insurance plan to provide coverage by restricting SUNY Downstate's disclosures to insurers; and
    f. Whether the restriction appears to be in the best interests of the patient.
3. Notify
    a. The patient must be notified of the decision to grant or deny the request. See attached Notice of Additional Privacy Protection Request Review form.
        i. the patient's request is approved, the notice should specify the restriction SUNY Downstate has agreed to abide.
        ii. If the patient's request is denied, the notice should specify the reason for the denial.
    b. If the restriction was approved, all hospital and medical staff involved in thepatient's care must be notified.
        i. A copy of the Notice of Additional Privacy Protection Request Review form should be attached to the Request for Additional Privacy Protection form and placed in the front of the medical record.
        ii. Eagle system must be updated to reflect the restriction.
        iii. All staff members must review the record to determine restrictions before using or disclosing the patient's PHI.

c. Patient Relations must notify business associates of restrictions agreed to by SUNY Downstate.

4. Exceptions- Agreements to all patient restrictions do not apply when the restricted PHI is:
    a. Needed to provide emergency treatment to the patient;
        i. Staff member must instruct individuals to whom PHI was disclosed for emergency treatment not to further use or disclose the information.
    b. Required by the Secretary of the US Department of Health and Human Services to investigate or determine compliance;
    c. Required for uses and disclosures that do not require the patient's authorization (See policy on Uses & Disclosures Not Requiring Patient Authorization);
    d. Needed for uses and disclosures for facility directories (See policy on Facility Directory).
5. Modifying or Terminating Restriction- All modifications or terminations of restrictions must be documented. See attached Modification/ Termination of Restrictions form.
    a. At the patient's request
        i. The patient should document the modification or termination on the form and sign it.
        ii. The Modification/ Termination of Restrictions form should be placed on top of the original Notice of Additional Privacy Protection form in the front of the medical record.
    b. At SUNY Downstate's request
        i. Any hospital or medical staff member who believes there is good reason to modify or terminate a restriction can present the reason to Patient Relations.
        ii. If Patient Relations, in conjunction with the appropriate department, determines that a modification or termination is granted, it should be documented on the Modification/ Termination of Restriction form.
        iii. Patient Relations representative must attempt to get the patient's signature, agreeing to the modification or termination.
        iv. If only an oral agreement can be obtained, Patient Relations representative should document the oral agreement on the form.
        v. If patient does not agree to the modification or termination, Patient Relations representative should document it on the form. The modification or termination of the restriction will only apply to PHI created or received on or after the date the patient was notified.
        vi. The Modification/ Termination of Restrictions form should be placed on top of the original Notice of Additional Privacy Protection form in the front of the medical record.
6. Documentation. The following documents must be maintained for six years from the date of creation:
    a. Requests for Additional Privacy Protection forms;
    b. Notice of Additional Privacy Protection Request Review forms;
    c. Modification/ Termination of Restriction forms.

B. Confidential Communications- Patients have a right to request that SUNY Downstate communicate with them about their medical matters in a method or location that is more confidential for them.

1. Obtain Written Request- Patient should document the request. See attached Requests for Additional Privacy Protection form.

a. An explanation from the patient as to the basis of the request may not be required as a condition of providing the communication on a confidential basis.
b. The patient must specify how information regarding payment should be handled, where necessary to comply with the request.
c. The patient must specify an alternate address or other method of contact, where necessary to comply with the request.

2. Evaluate the Request- Patient Relations representative should evaluate the request to determine whether SUNY Downstate can reasonably comply with the request. The following factors should be considered:
    a. Whether the restriction may cause SUNY Downstate to violate applicable federal or state law. Patient Relations should contact the Privacy Director and/or legal counsel for assistance.
    b. Whether the restriction may cause SUNY Downstate to violate professional standards, including medical ethical standards;
    c. Whether SUNY Downstate will be able to communicate with the patient promptly and effectively if it complies with the alternative method of communication;
    d. Whether SUNY Downstate will have the ability to apply the alternative method of communication consistently;
    e. Whether the alternative method of communication would place an unreasonable financial burden on SUNY Downstate;
    f. Whether the patient has provided adequate assurances of how payment will be handled if SUNY Downstate agrees to the alternative method of communication.
3. Notify
    a. The patient must be notified of the decision to grant or deny the request. See attached Notice of Additional Privacy Protection Request Review form.
        i. If the patient's request is approved, the notice should specify the alternate method of communication that SUNY Downstate has agreed to abide.
        ii. If the patient's request is denied, the notice should specify the reason for the denial.
    b. If the alternative method of communication was approved, all hospital and medical staff involved in the patient's care must be notified.
        i. A copy of the Notice of Additional Privacy Protection Request Review form should be attached to the original Request for Additional Privacy Protection and placed in the front of the medical record.
        ii. Eagle system must be updated to reflect the alternative method of communication.
        iii. All staff members must review the record to determine any alternative method of communication.
    c. The appropriate department must notify business associates of alternative method of communication agreed to by SUNY Downstate.
4. Documentation- The following documents must be maintained for six years from the date of creation:
    a. Requests for Additional Privacy Protection forms;
    b. Notice of Additional Privacy Protection Request Review forms.

VI. ATTACHMENTS

Requests for Additional Privacy Protection, Notice of Additional Privacy Protection Request Review, Modification/ Termination of Restriction

VII. REFERENCES

Standards for Privacy of Individually Identifiable Health Information, 45 CFR §164.522

	Revision	Required	Responsible Staff Name and Title
12/07	**Yes**	**No**	**Adeola O. Dabiri, Director Regulatory Affairs**
	Yes	**No**	

SUNY DOWNSTATE Medical Center

REQUESTS FOR ADDITIONAL PRIVACY PROTECTION

Patient Name: _____
Last Name First Name MI

Address: _____ Telephone:

_____ _____ (daytime)

_____ _____ (evening)

Request for Restriction

As our patient, you have the right to request that we restrict the way we use or disclose your protected health information for treatment, payment or healthcare operations. SUNY Downstate Medical Center is not required to agree to your request for a restriction. If we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or to comply with the law.

What information do you want to restrict?

_____

_____

_____

How do you want us to restrict the information and when should the restrictions apply?

_____

_____

_____

Request for Confidential Communication

As our patient, you have the right to request that we communicate with you about your medical matters in a method or location that is more confidential for you. We will not ask you the reason for your request.

What is the alternative method or location of communication that you are requesting?

_____

_____

_____

How will payment, if any, be handled if we agree to communicate with you through this alternative method or location?

_____

_____

_____

By signing below, I certify that I am requesting that SUNY Downstate Medical Center University Hospital of Brooklyn afford me with additional privacy protections as stated above.

_____ _____
Print Name of Patient/ Personal Representative Signature of Patient/ Personal Representative

_____ _____
Description of Personal Representative's Authority Date

SUNY DOWNSTATE Medical Center

NOTICE OF ADDITIONAL PRIVACY PROTECTION REQUEST REVIEW

[Date]

[Patient Name]
[Street Address 1]
[Street Address 2]
[City, State Zip Code]

Re: Request For Additional Privacy Protection

Dear [Patient Name]:

This letter responds to your request, received from you on _____, that we

- ❑ RESTRICT YOUR INFORMATION
- ❑ CONTACT YOU AT AN ALTERNATIVE METHOD OR LOCATION.

We have reviewed your request and:

❑ Agree to your request for additional privacy protection in the following manner:

_____
_____
_____
_____

❑ Deny your request because of the following reason:

- ❑ The additional privacy protection may cause us to violate a law.
- ❑ The additional privacy protection may cause us to violate professional standards.
- ❑ Our information systems make it unfeasible to accommodate your request.
- ❑ Your request may impede us from treating you appropriately.
- ❑ You have not specified an alternative payment arrangement.
- ❑ We do not feel that your request is in your best interests as our patient.
- ❑ Your request may impede us from communicating with you effectively.
- ❑ We cannot abide by your request consistently.
- ❑ Your request places an unreasonable financial burden upon us.

Please contact the Patient Relations Department at (718) 270-1111 if you have questions or concerns.

A COPY OF THIS NOTICE MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD.

SUNY DOWNSTATE Medical Center

MODIFICATION/ TERMINATION OF RESTRICTION

This is a modification or termination of the patient's request of __/__/__ for a restriction of his/her information.

This modification or termination is a result of a request from:

- ❑ Patient
- ❑ SUNY Downstate Medical Center

MODIFICATION: The patient's request for restriction is being modified in the following manner:

_____

_____

_____

_____

TERMINATION: The patient's request for restriction is being terminated. Document reason (if any):

_____

_____

_____

_____

- ❑ Patient agrees to modification/ termination.

  _____ _____
  Signature of Patient or Personal Representative Date

- ❑ Patient orally agrees to modification/ termination.

  _____ _____
  Signature of SUNY Downstate Member Date

- ❑ Patient does not agree to modification/ termination.
  Modification/ Termination is only applicable after patient notification date of ___/___/___.

THIS FORM MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD ON TOP OF THE NOTICE OF ADDITIONAL PRIVACY PROTECTION REQUEST REVIEW FORM.