

-UNIVERSITY PHYSICIANS OF BROOKLYN, INC.

POLICY AND PROCEDURE

		No: _____
Subject:	PATIENT REQUESTS FOR ADDITIONAL PRIVACY PROTECTIONS	Page 1 of 4
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Prepared by:	Shoshana Milstein	Original Issue Date: NEW
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Reviewed by:	HIPAA Policy & Procedure Team	Supersedes Date: NONE
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		Approval Date: 11/02
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Approved by:	HIPAA Oversight Committee	Distribution:
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- 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:** UPB 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. **Procedure**
- A. Restrictions on Uses & Disclosures of PHI-** Patients have a right to request that UPB 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- The Practice manager 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 UPB to violate applicable federal or state law. The Privacy Director and/or legal counsel should be contacted for assistance.
- b. Whether the restriction may cause UPB to violate professional standards, including medical ethical standards;
- c. Whether UPB's information systems make it unfeasible to accommodate the request;
- d. Whether the restriction may unreasonably impede UPB'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 UPB'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. If the patient's request is approved, the notice should specify the restriction UPB 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 practice 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 Request for Additional Privacy Protection form and placed in the front of the medical record.
 - ii. The applicable computer system should 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. The Practice must notify its business associates of restrictions agreed to by UPB.

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 UPB's request
 - i. Any practice or medical staff member who believes there is good reason to modify or terminate a restriction can present the reason to the Practice manager.
 - ii. If the Practice manager determines that a modification or termination is granted, it should be documented on the Modification/ Termination of Restriction form.
 - iii. The Practice manager must attempt to get the patient's signature, agreeing to the modification or termination.
 - iv. If only an oral agreement can be obtained, the Practice manager should document the oral agreement on the form.
 - v. If patient does not agree to the modification or termination, the Practice manager 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 UPB 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- The Practice manager should evaluate the request to determine whether UPB can reasonably comply with the request. The following factors should be considered:
 - a. Whether the restriction may cause UPB to violate applicable federal or state law. The Practice manager should contact the Privacy Director and/or legal counsel for assistance.
 - b. Whether the restriction may cause UPB to violate professional standards, including medical ethical standards;
 - c. Whether UPB will be able to communicate with the patient promptly and effectively if it complies with the alternative method of communication;
 - d. Whether UPB 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 UPB;
 - f. Whether the patient has provided adequate assurances of how payment will be handled if UPB 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 UPB 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 practice 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. The applicable computer 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 practice must notify business associates of alternative method of communication agreed to by UPB.
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.

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

V. Reasons for Revision: Regulatory changes

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



**UNIVERSITY
PHYSICIANS**
BROOKLYN, INC.

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. University Physicians of Brooklyn, Inc. 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 University Physicians of Brooklyn, Inc. 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



**UNIVERSITY
PHYSICIANS**
BROOKLYN, INC.

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:

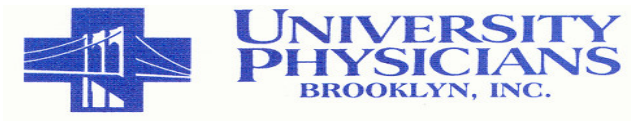
☐ Agree to your request for additional privacy protection in the following manner:

☐ 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 _____ at (____) ____-____ if you have questions or concerns.

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



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
- ☐ University Physicians of Brooklyn, Inc.

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 UPB 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.**