

NAME OF HOSPITAL

HIPAA REGULATION	INDIVIDUAL RIGHTS	REFERENCE: 5.2
SUBJECT:	RIGHT TO REQUEST RESTRICTION ON USE OR DISCLOSURE	EFFECTIVE: 00/00/2003
DEPARTMENT:	HOSPITAL WIDE	
APPROVED BY:		REVISED:

_____ has adopted a policy on an individuals right to request that a covered entity restrict the use or disclosure of PHI to comply with our obligations under the privacy standards.

POLICY: INDIVIDUALS RIGHT TO REQUEST RESTRICTION ON THE USE OR DISCLOSURE OF PRIVATE HEALTH INFORMATION

It is the policy of _____ that individuals have the right to request that his/her individual healthcare information be treated as confidential and private except if needed for treatment, insurance payment or for healthcare operations. The privacy rules entitle individuals to make this request; a covered entity is not required to agree to any such requested restrictions.

- A patient has the right to request the restriction of access to his/her private medical information.
- A patient can request that his/her private medical information not be provided to family members. The request and the action taken will be recorded on the patient's medical record.
- A patient can verbally request that access to his/her private medical information be restricted. The agreement or disagreement to this request will be recorded in the patient's medical record.
- _____ can terminate the agreement to restrict a patient's private medical information if the information is needed to provide emergency care or treatment. Any information obtained to help provide emergency care cannot be used beyond the provision of emergency care.
- Should the organization decide to terminate a restriction agreement with a patient without the patient's agreement, any information prior to the termination will need to be maintained as confidential and private. Medical information after the date and time of the notice of agreement termination would not be held as confidential and private.
- _____ will maintain a record of agreed restrictions. This record shall be retained for six (6) years from the date it was created or the date it was last in effect, whichever is later.

Please contact the person listed below with questions on this policy and/or to report violations.

Name:
Phone number:
Address:
Fax:

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DEPARTMENT:	HOSPITAL WIDE	
APPROVED BY:		REVISED:

_____ has adopted the following procedure to implement the policy on an individuals right to request that a covered entity restrict the use or disclosure of PHI to comply with our obligations under the privacy standards.

PROCEDURE: FOR MAINTAINING INDIVIDUALS RIGHT TO REQUEST RESTRICTION ON THE USE OR DISCLOSURE OF PRIVATE HEALTH INFORMATION

- Inform the patient in the “Notice of Privacy Practices” of his/her rights to have his/her private medical information maintained as confidential and private.
- Inform the patient in the “Notice of Privacy Practices” of who will have access to his/her personal medical information and that she/he has the right to restrict access to his/her personal medical information.
- Should the patient request his/her health information be restricted, the patient must complete and sign the “Request to Restrict or Limit the Use or Disclosure of Protected Health Information” form.
- The completed “Request to Restrict or Limit the Use or disclosure of Protected Health Information” form is to be maintained in the patient’s medical record.
- A record of the completed “Request to Restrict or Limit the Use or disclosure of Protected Health Information” form will be maintained for a period of six (6) years from either the date created or the date in which it is was last in effect.
- _____ can terminate the agreement only after informing the patient of the termination of the agreement. Once the patient is notified, _____ must maintain the confidentiality of the information in the original agreement prior to the termination of the agreement. Information accumulated after the notification to terminate the agreement would not be covered or restricted by the terms of the previous agreement.

Please contact the person listed below with questions on these procedures and/or to report violations.

Name:
Phone number:
Address:
Fax: