SUBJECT: ALTERNATIVE MEANS

GENERAL STANDARD (PRIVACY RULE SECTION 164.522(b)):

AHS health care providers and health plans must respond to requests by individuals (or their personal representatives) for communications of PHI by alternative means, or at alternative locations. In most situations, AHS will accept these requests.

I. Confidential Communications Requirement

A. A covered health care provider must permit individuals to request and must accommodate reasonable requests by individuals to receive communications of PHI from the covered health care provider by alternative means or at alternative locations.

B. A health plan must permit individuals to request and must accommodate reasonable requests by individuals to receive communications of PHI from the health plan by alternative means or at alternative locations, if the individual clearly states that the disclosure of all or part of that information could endanger the individual.

II. Conditions on Providing Confidential Communications

A. A CE may require the individual to make a request for a confidential communication described above in writing.

B. A CE may condition the provision of a reasonable accommodation on:

1. When appropriate, information as to how payment, if any, will be handled; and

2. Specification of an alternative address or other method of contact.

C. A covered health care provider may not require an explanation from the individual as to the basis for the request as a condition of providing communications on a confidential basis.

D. A health plan may require that a request contain a statement that disclosure of all or part of the information to which the request pertains could endanger the individual.

GUIDELINES:

1. A patient, beneficiary or his/her personal representative may request to receive communications of PHI from AHS by alternative means or at alternative locations.

2. AHS requires each such patient, beneficiary or personal representative to make such requests in writing, and to specify the alternative location or other method of communication. Form letters for this purpose (one for health care providers, and the other for health plans) are attached to this Standard and Guidelines.

3. AHS health care providers will **not** require an explanation from a patient or his/her personal representative as to the basis for a request as a condition of providing communications on a confidential basis.

4. AHS health plans will **not** require an explanation from a beneficiary or his/her personal representative as to the basis for a request as a condition of providing communications on a confidential basis, however, AHS health plans will require a statement that disclosure of all or part of the information to which the request pertains could endanger the individual (the form letter attached to this Standard and Guidelines for health plans contains such a statement).

5. AHS health care providers and health plans will grant all such requests, unless a request imposes an unreasonable administrative burden (in that event, the request will be reviewed with the Privacy Official and the HIPAA contact for the AHS Department, Division or Office at issue, before any denial of the request is communicated to the patient, beneficiary, or his/her personal representative). However, AHS health care providers and health plans may condition the provision of an accommodation on information as to how payment, if any, will be handled, and specification of an alternative address or other method of contact (the form letters attached to this Standard and Guidelines address these issues).

6. Written documentation of the request from the patient, beneficiary, or his/her personal representative, and any AHS response, will be placed in the appropriate record.

7. If a request is granted, AHS will inform all staff who provide care or services to the patient, beneficiary or his/her personal representative of the new communication requirements, and that they must adhere to those requirements.

Form Letter: Request for Confidential Communications (Health Care Provider)

Patient Name: _____ Birth Date: ___ /_____/___
MM/DD/YR

Address _____
Home Telephone Number: _____ E-mail: _____
Patient Identification Number and/or Social Security Number: _____

I, _____, am requesting that _____ communicate with me in the alternative manner and/or location described below regarding my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996). I understand that _____ may deny this request if it imposes an unreasonable administrative burden. I also understand that _____ may condition its approval of this request on information as to how payment, if any, for services will be handed.

Description of the Health Information that Must be Communicated Confidentially. The following is a description of the specific health information to which this request applies:

_____

_____

Alternative Manner and/or Location. I request that _____ only communicate with me in the following manner and/or at the location described below:

_____

_____

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____/_____/_____
Signature Date

If signed by personal representative:

Name of personal representative: _____

Relationship to patient or nature of authority: _____

_____ _____/_____/_____
Signature of Personal Representative Date

I. **Submit Form to: [Insert title of contact person, telephone number and address]**

Form Letter: Request for Confidential Communications (Health Plan)

Name: _____ Birth Date: ___ /_____/___
MM/DD/YR

Address _____

Home Telephone Number: _____ E-mail: _____

Identification Number and/or Social Security Number: _____

I, _____, am requesting that _____ communicate with me in the alternative manner and/or location described below regarding my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996). I understand that _____ may deny this request if it imposes an unreasonable administrative burden. Such restriction is necessary to prevent a disclosure that could endanger me. I also understand that _____ may condition its approval of this request on information as to how payment, if any, for services will be handed.

Description of the Health Information that Must be Communicated Confidentially. The following is a description of the specific health information to which this request applies:

_____

_____

Alternative Manner and/or Location. I request that _____ only communicate with me in the following manner and/or at the location described below:

_____

_____

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____/_____/_____
Signature Date

If signed by personal representative:

Name of personal representative: _____

Relationship to individual or nature of authority: _____

_____ _____/_____/_____
Signature of Personal Representative Date

II. Submit Form to: [Insert title of contact person, telephone number and address]