SUBJECT: RESTRICTIONS

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

An AHS health care provider or health plan must permit individuals (or their personal representatives) to request restrictions in the manner in which the health care providers or health plans would otherwise use or disclose PHI, in certain situations (e.g., with respect to treatment, payment or health care operations activities). AHS is not required to agree to any requested restriction.

PRIVACY RULE:

I. Rights to Request Privacy Protection for PHI

A. A CE must permit an individual to request that the CE restrict:

1. Uses or disclosures of PHI about the individual to carry out treatment, payment or healthcare operations; and

2. Disclosures permitted under Section 164.510(b) (See, the AHS Standard and Guidelines on "Family and Friends").

A CE is not required to agree to any requested restriction.

II. Restrictions

A. If a CE agrees to a restriction, it may not use or disclose PHI in violation of such restriction, except that, if the individual who requested the restriction is in need of emergency treatment and the restricted PHI is needed to provide the emergency treatment, the CE may use the restricted PHI, or may disclose such information to a health care provider, to provide such treatment to the individual. If restricted PHI is disclosed to a health care provider for emergency treatment, the CE must request that such health care provider not further use or disclose the information.

B. A restriction agreed to by the CE is not effective to prevent uses or disclosures permitted or required under Section 164.502(a)(2)(ii) (i.e., disclosures to the Secretary of the Department of Health and Human Services for compliance reviews), Section 164.510(a) (See, the AHS Standard and Guidelines on "Facility Directories"), or Section 164.512 (See, the AHS Standards and Guidelines on "External Parties", "Legal Requirements", and "Research").

III. Terminating Restriction to Request Privacy Protection for PHI

A. A CE may terminate its agreement to a restriction if:

1. the individual agrees to or requests termination in writing;

2. the individual orally agrees to the termination and the oral agreement is documented; or

3. the CE informs the individual that it is terminating the restriction agreement, except that such termination is only effective with respect to PHI created or received after the CE has so informed the individual.

IV. Documentation of a Restriction Agreement

A CE will document any agreed upon restriction in either electronic or written form and retain such documentation for a period of six years from the date of its creation or when it last was in effect, whichever is later.

GUIDELINES:

1. AHS informs each patient, beneficiary, or his/her personal representative of the right to request restrictions on the use and disclosure of PHI through its Notices of Privacy Practices (e.g., in the Vermont State Hospital Notice of Privacy Practices, and in the Notice of Privacy Practices used by the Department of Prevention, Assistance, Transition and Health Access).

2. Workforce members or Business Associates may not grant or deny a request for restrictions without prior authorization from the Privacy Official or the HIPAA contact for the AHS Department, Division or Office that receives a restriction request – AHS has trained its workforce to this effect, and so instructed its Business Associates (where necessary).

3. As a rule, AHS will not grant any requested restriction, because of the administrative difficulties in tracking and subsequently honoring a request. However, a patient, beneficiary or his/her personal representative is free to make any desired request. In addition, AHS may provide the patient, beneficiary or his/her personal representative with a form letter to use when making such a request. A copy of such a letter is attached to this Standard and Guidelines.

4. If AHS grants a request:

   A. the patient, beneficiary or his/her personal representative will be notified of any potential consequences of the restriction (e.g., consequences on treatment);

   B. a notation will be made in the appropriate record;

C. AHS will not use or disclose PHI inconsistent with the agreed restriction, nor will AHS Business Associates (and AHS will inform such Business Associates of the restriction and secure their compliance with it);

D. the patient, beneficiary, or his/her personal representative will be informed that AHS is not required to comply with the agreed upon restriction in emergency treatment situations when the restricted PHI is necessary for treatment (in that event, AHS will request that any health care provider to whom it discloses the restricted PHI not further use or disclose the information);

E. if the agreed upon restriction hampers treatment, AHS will ask the patient/beneficiary or his/her personal representative to modify or revoke the restriction and get written agreement to the modification or revocation or document an oral agreement; and

F. written documentation of the agreed to restriction will be maintained for six (6) years from the date of its creation or the date when it was last in effect, whichever is later.

5. If AHS denies a request, then the patient, beneficiary or his/her personal representative will be given the opportunity to discuss his or her privacy concerns, if desired.

Form Letter: Request for Restrictions on Use and Disclosure of PHI

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

Address: _____
_____

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

I, _____, am requesting a restriction on _____ use and/or disclosure of 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) in the manner described below. **I understand that _____ may deny this request for any reason.** I also understand that if agreed to, _____ may not be able to honor this request if I require emergency treatment and that the _____ may remove this restriction in the future, if I am notified in advance.

Description of Restriction of the Health Information to be Used or Disclosed. The following is a description of the specific health information I wish to restrict:

_____

_____

Persons/Organizations Restricted from Use and/or Disclosure of Health Information. I request that the following person(s) and/or organization(s) not be allowed to use, receive and/or disclose the health information described above.

_____

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