

3364-90-03 Request for restriction of health information.**(A) Policy statement**

Individuals have the right to request restrictions on their protected health information “PHI” from the health information management department. Restrictions may be denied in accordance with the privacy laws.

(B) Purpose of policy

The purpose of this policy is to provide guidance on when and how an individual may request a restriction of their PHI and to outline the processes set out by the compliance and privacy office and health information management “HIM” in processing such requests.

(C) Procedure**(1) Individual rights**

Patients or their designated representative may request restrictions on the use and disclosure of their PHI for treatment, payment and operations. Individuals may also request a restriction of use and disclosure of PHI to family members and others identified by the individual as well as to public or private agencies authorized to carry out disaster relief activities. Hybrid and affiliated covered entities of the university of Toledo “UT” (hybrid and affiliated covered entity “ACE” of UT) reserve the right to grant or deny a request for restriction except in the following situation:

- (a) Disclosure to a health plan for the purpose of payment or healthcare operations.**
- (b) The PHI pertains solely to a healthcare service for which the patient or another person other than the health plan has paid out of pocket and in full on behalf of the patient.**

An individual’s request for restriction must be granted in this event unless the restriction is prohibited by law.

(2) How to request a restriction

The request for restriction must be made by completing and submitting, within three calendar days of service, a “request for restrictions on protected health information” form (attached to this policy) provided to the patient by financial services, health information management department “HIM” or the compliance and privacy office or in other writing to HIM. HIM, in conjunction with the privacy office, will review and make a decision on the request. A copy of the final decision pertaining to the individual’s request for a restriction will be provided to the individual.

(3) Update and downstream users

If the request for a restriction is granted, all pertinent systems will be updated relative to the restriction. A copy of the request and decision will be scanned into the patient's medical record. The individual is responsible for notifying all downstream healthcare providers.

(4) Limitations on request for restrictions

Hybrid and ACE of UT will not disclose PHI where a request for restriction has been granted, except if any of the following apply:

- (a) In the event of an emergency, 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 restricted PHI may be disclosed to a healthcare provider, in order to provide treatment to the individual. A healthcare provider may not further use or disclose restricted PHI after the emergency treatment of the individual.
- (b) The agreement is rendered ineffective by law such as when disclosure is required by the secretary of health and human services, certain uses of PHI in institutional directories, disclosures for public health purposes, law enforcement, judicial or administrative proceedings health oversight activities and report of victims of abuse, neglect or domestic violence.

(5) Termination of agreement to restrict PHI

HIM, in conjunction with the privacy office, may terminate its agreement to a restriction if:

- (a) The individual agrees to or requests the termination in writing.
- (b) The individual orally agrees to the termination and the oral agreement is documented.
- (c) HIM informs the individual that it is terminating its agreement to a restriction, except that such termination is ineffective for restrictions to health plans for purposes described in paragraph (C)(1) of this rule. In addition, a unilateral termination is only effective with respect to PHI created and received after the individual has been duly informed.

(6) Restriction request - pay in full*

- (a) Hybrid and ACE of UT are required to honor requests not to disclose PHI to your health plan when the patient is paying out of pocket for the full cost of services.
- (b) Hybrid and ACE of UT are not required to honor requests when the patient is not paying in full, as promised. At that time, the Hybrid and ACE of UT will submit a claim to the patient's health plan or initiate other collection activities. This means if the full payment does not go through for any reason, e.g., bounced check or credit card denied, the hybrid and ACE of UT will contact the patient's health plan for reimbursement.
- (c) Hybrid and ACE of UT cannot honor a request to restrict the entity from giving PHI to an insurance company that will be asked to pay a portion of a patient's bill.

*Not subject to any discount

Signature of UMC Privacy Officer

Date



REQUEST FOR RESTRICTIONS ON
PROTECTED HEALTH INFORMATION (PHI)

Privacy Office
3065 Arlington Avenue Mulford Library 224
Toledo, Ohio 43614 419 383-4994

Patient Name: _____

Birth date: _____

Social Security Number: _____

I request that my protected health information not be disclosed to:

Anyone (including health plans) for the purposes of treatment, payment or healthcare operations.

Please specify name of health plan _____

Family or other individual (s)

Please specify name of individual (s) _____

Authorized disaster relief organization for disaster relief purposes.

Health plan only for the purpose of payment or healthcare operations (**Payment in full required**)

Please specify name of health plan _____

Select type of personal information you would like to restrict

Only information from my visit on (dd/mm/yyyy) _____

Other Please specify _____

Please communicate your decision regarding this request to me at:

Street:

City/ Town:

State:

Telephone number:

I understand that UTMC is not required to grant my request and that disclosures required by law may not be restricted. I also understand that should my request be granted, UTMC is not responsible for notifying healthcare providers who are outside of its network of providers of the restrictions.

Signature of Patient/Legal Representative (relationship)

Date

For Office Use Only:

Total Charges: \$ _____

Total Payment: \$ _____

Effective: 7/9/2018

CERTIFIED ELECTRONICALLY

Certification

06/29/2018

Date

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