LOUISIANA STATE UNIVERSITY
HEALTH CARE SERVICES DIVISION
BATON ROUGE, LA

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INQUIRIES TO:	**LSU HCSD** **Compliance Section** **Post Office Box 91308** **Baton Rouge, LA 70803** **Telephone: 225-354-4840**

Note: Approval signatures/titles are on the last page

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Patient's Right to Request a Restriction of the Uses and Disclosures of their PHI

I. SCOPE

This policy is applicable to all workforce members of the LSU Health Care Services Division facilities, including employees, physician/practitioner practices, vendors, agencies, business associates and affiliates. Any reference herein to LSU Health Care Services Division also applies and pertains to Lallie Kemp Medical Center (LKMC).

II. PURPOSE

To provide guidance to the LSU HCSD on a patient's right to request restriction of the uses and disclosures of their Protected Health Information to carry out treatment, payment, health care operations, or for involvement in the individual's care and notification purposes as required by the Health Insurance Portability and Accountability Act, Standards for Privacy of Individually Identifiable Health Information (HIPAA Privacy Regulations), and any other applicable state or federal laws or regulations.

III. POLICY

All LSU HCSD facilities and providers must provide patients with a right to request a restriction of the uses and disclosures of their Protected Health Information that is contained in a Designated Record Set. The HIPAA Privacy Regulations require health care providers to provide patients with a right of access to inspect and obtain a copy of their Protected Health Information.

IV. DEFINITIONS

A. **Protected Health Information (PHI)** – for purposes of this policy means individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. It includes demographic data that relates to that relates to:

1. The individual's past, present, or future physical or mental health or condition;
2. The provision of health care to the individual; or
3. The past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. PHI includes many common identifiers such as name, address, birth date, social security number, etc.

B. **Privacy Officer** - Person designated by the Facility as the Privacy Officer.

C. **Designated Record Set** – a group of records maintained by or for the Facility that is:

1. The medical records and billing records about individuals maintained by or for the Facility; or
2. Any records used, in whole or part, by or for the Facility to make decisions about individuals.
3. Any record that meets this definition of Designated Record Set and which are held by a HIPAA Business Associate of Facility or Clinic are part of the Facility's Designated Record Set.

    a. The term *record* means any item, collection, or grouping of information that includes PHI and is created, maintained, collected, used or disseminated by or for the Facility.
    b. The term *record* also includes patient information originated by another health care provider and used by the Facility to make decisions about a patient.
    c. The term *record* includes tracings, photographs, and videotapes, digital and other images that may be recorded to document care of the patient.

V. PROCEDURE

A. A patient has the right to request in writing that the Facility restrict (see Attachment A):

1. Uses or disclosures of PHI about the patient used to carry out treatment, payment or health care operations; and

2. Disclosures of PHI to persons involved with the patient's care or payment or for notification purposes.

3. Disclosures of PHI to the patient's health plan insurer, if the patient chooses to pay for the service out of pocket. The processes related to this restriction are separate and distinct from the processes outlined in this policy and are addressed in HCSD Policy 7530.

B. The patient's request for restriction should be forwarded to the HIM Director or designee who will determine whether the request can be accommodated.

C. The Facility does **not** have to agree to a restriction requested by the patient. If the

HIM Director or designee agrees to a requested restriction the patient shall be notified in writing that the request has been granted.

D. If the requested restriction is denied, the patient should be notified in writing of the denial (See Attachment B).

E. If the HIM Director or designee agrees to the restriction, the Facility must abide by such restriction, except:

1. If the patient is in need of emergency treatment and the restricted PHI is needed to provide the emergency treatment.

2. If restricted PHI is disclosed to a health care provider, the Facility must request that the health care provider not further use or disclose the restricted PHI.

F. A restriction agreed to by the Facility is not effective to prevent uses or disclosures permitted or required for HHS investigations, facility directory purposes or required by law for public health purposes (§164.502(a)(2)(ii), 164.510(a), or 164.512).

G. The Facility may terminate its agreement to a restriction, if:

1. The patient agrees to or requests the termination in writing (See Attachment C);

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

3. The Facility informs the patient that it is terminating the agreement. This termination is only effective with respect to Protected Health Information created or received after the Facility has informed the patient.

H. All correspondence and associated documentation related to patient requests for restrictions, including denials, must be maintained and retained for 6 years.

REFERENCE: 45 C.F.R. § 164.522

Attachment A

Restricting Uses and Disclosures of Protected Health Information

Patient Request for Restrictions to Use and Disclosure of Protected Health Information

I request _____to restrict the use and disclosure of the following protected
(Name of Facility)
health information (PHI). I understand that _____may not agree to this
(Name of Facility)
request. **Describe the restriction requested:**

_____

_____

This restriction shall be in effect until _____.
(date or event)

Patient Name, printed:

_____

Signature: _____ Date: _____

Relationship if not patient: _____

Mailing Address for future correspondence regarding this restriction:_____

_____

Attachment B

Facility Response to Patient Request for Restriction of Use and Disclosure of Protected Health Information

_____ has reviewed the above request to restrict the use and disclosure of
(Name of Facility)
protected health information (PHI) and **(check one)**

☐ Denies the request as the facility cannot reasonably assure or guarantee the restriction can be met.

☐ Accepts and will honor the request for the stated restriction. If you need emergency treatment and the restricted PHI is needed to provide emergency treatment, we may use the restricted PHI or may disclose this information to another health care provider to provide you with the emergency treatment. We will ask the health care provider to not further use or disclose the PHI. In addition, in the future we may need to terminate or revoke our acceptance of this restriction. We will notify you of such unilateral termination.

Signed:_____ Date: _____

Title: _____

Revoking or Terminating Restriction of Use and Disclosure of Protected Health Information

Check One:

☐ **Patient:** I hereby **revoke** the above restriction of the use and disclosure of my protected health information (PHI) effective _____(date).

☐ **Facility:** _____(name of facility) previously agreed to the above restriction of the use and disclosure of your protected health information (PHI). _____(name of facility) **terminates this previous agreement** and we no longer will restrict the use and disclosure of your Protected Health Information effective _____(date).

Signed: _____ Date: _____

Printed Name: _____

Relationship if not patient: _____
OR
Title of Facility Personnel: _____

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