**LOUISIANA STATE UNIVERSITY**
**HEALTH CARE SERVICES DIVISION**
**BATON ROUGE, LA**

**POLICY NUMBER**: 7506-25

**CATEGORY**: HIPAA Policies

**CONTENT**: Patient's Right to Request to Receive Confidential Communications by Alternative Means or at Alternative Locations
- Form to make request (Attachment A)

**APPLICABILITY**: This policy is applicable to Health Care Services Division Administration (HCSDA) and Lallie Kemp Medical Center (LKMC) to include employees, physician/practitioner practices, vendors, agencies, business associates and affiliates.

**EFFECTIVE DATE**

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| Issued: | April 14, 2003 |
| Revised: | December 7, 2007 |
| Revised: | January 26, 2009 |
| Reviewed: | August 13, 2010 |
| Reviewed: | March 23, 2012 |
| Revised: | July 23, 2013 |
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| Reviewed: | July 14, 2025 |

**INQUIRIES TO**: HCSD
Compliance Section
Post Office Box 91308
Baton Rouge, LA 70803

**Note: Approval signatures/titles are on the last page**

# LSU HEALTH CARE SERVICES DIVISION
# PATIENT'S RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS BY ALTERNATIVE MEANS OR AT ALTERNATIVE LOCATIONS

## I. STATEMENT OF POLICY

All facilities and providers of the LSU Health Care Services Division (HCSD) must provide patients with a right to request and must accommodate reasonable requests initiated by individuals to receive confidential communications by alternative means or at alternative locations of their Protected Health Information (PHI).

**Note:** Any reference herein to HCSD also applies and pertains to Lallie Kemp Medical Center (LKMC).

## II. PURPOSE

To provide guidance to the health care facilities and providers affiliated with HCSD on a patient's right to request to receive confidential communications by alternative means or at alternative locations of their Protected Health Information, as required by the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (HIPAA Privacy Regulations), and any other applicable state or federal laws or regulations.

## III. IMPLEMENTATION

This policy and subsequent revisions to the policy shall become effective upon approval and signature of the HCSD Chief Executive Officer (CEO) or Designee.

Each facility shall be responsible for developing a written process to ensure that the contents of this policy are implemented

## IV. DEFINITIONS

A. **Protected Health Information (sometime referred to as "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. Includes demographic data 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 identified 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. **Admit/Screening Representative** – Person designated by the Facility as the visit processor. Individual identified by the Facility to be responsible for receiving and processing requests to receive communications of their PHI by alternative means or at alternative locations.

## V. PROCEDURE

A. A patient may make a request in writing to the Facility to receive communications of their PHI by alternative means or at alternative locations. This request may occur at any time. The patient cannot be required to provide an explanation for their request. A patient should be asked to complete Attachment A when making such request.

B. The request should be given to the Admit/Screening Representative who will be responsible for receiving requests for confidential communications and communicate it to the appropriate employees.

C. The Facility is only required to handle requests that are reasonable. The reasonableness of a request must be determined by the Facility solely on the basis of the administrative difficulty of complying with the request. Should there be any question about the reasonableness of the request, the Admit/Screening Representative shall confer with his/her supervisor or the HIPAA Privacy Officer.

D. Examples of the types of communications subject to this policy include, but are not limited to:

1. A request by the patient that the Facility communicate with the individual about their treatment at the individual's place of employment, by mail to a designated phone number;
2. Mailing or telephoning of appointment reminders to a particular location or number;
3. Prescription refill reminders to a particular address;
4. Mailing bills or statements to a particular address; or
5. Request to send communications in a closed envelope rather than a post card.

E. Requests for confidential communication must include the patient's designation of the means and location of alternative delivery of the PHI. For example, these requests may include, but not be limited to:

1. Communication by telephone to an alternative phone number;

2. Mail to an address other than the address of record;
3. A request for **only** telephone communication;
4. Sealed envelope delivery rather than a post card; or
5. Mail to an alternate address.

F. The patient should be informed if the Facility is not able to meet the request for confidential communications.

G. The patient's request for confidential communication should be documented in the patient's medical and billing records and the original copy of the request form will be scanned into the patient's medical record.

## VI. EXCEPTION

The HCSD CEO or designee may waive, suspend, change or otherwise deviate from any provision to this policy they deem necessary to meet the needs of the agency as long as it does not violate the intent of this policy, state and/or federal laws, Civil Service Rules and Regulations, LSU Policies/Memoranda, or any other governing body's regulations.

**Attachment A**

## REQUEST TO RECEIVE CONFIDENTIAL INFORMATION BY ALTERNATIVE MEANS OR AT ALTERNATIVE LOCATIONS

I, _____, request that I receive my Protected Health Information by alternative means or at an alternative location. I understand this request applies only to communications between _____ and me.
(Facility or Clinic)

**PLEASE USE THE FOLLOWING TO CONTACT ME:**

Mailing Address: _____

_____

_____

Telephone Number: _____

Other: _____

**THIS REQUEST WILL REMAIN IN EFFECT UNTIL YOU NOTIFY US OTHERWISE.**

_____ _____
Signature of Patient or Personal Representative Date

_____
Printed Name of Patient or Personal Representative

_____
Documentation of Personal Representative's Authority

Date of Birth: _____ Patient's S.S. #: _____

Original: Patient's Medical Record

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| Creator: | Reeves, Rebecca<br>*Compliance and Privacy Officer* |
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| Owner/SME: | Reeves, Rebecca<br>*Compliance and Privacy Officer* |
| Manager: | Reeves, Rebecca<br>*Compliance and Privacy Officer* |
| Author(s): | Wicker, Claire M.<br>*PROJECT COORDINATOR*<br>Reeves, Rebecca<br>*Compliance and Privacy Officer* |
| Approver(s): | Wilbright, Wayne<br>*Chief Medical Informatics Officer*<br>Reeves, Rebecca<br>*Compliance and Privacy Officer* |
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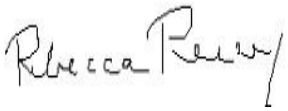
Digital Signatures:

Currently Signed

Approver:
Reeves, Rebecca
Compliance and Privacy Officer



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Approver:
Wilbright, Wayne
Chief Medical Informatics Officer

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