## POLICY INFORMATION

**Policy Title:** Patient Rights to Request Restrictions

**Departmental Owner**: Chief Compliance, Audit, and Privacy Officer

**Version Effective Date**: 07/17/2024

**Last Reviewed**: 07/17/2024

## SCOPE

This policy applies to the following individuals and/or groups:

☒All of the below categories

☐All Employees ☐CT Employees ☐NY Employees ☐Remote Employees ☐Contractors☐Volunteers ☐Students/Interns ☐Vendors

This policy applies to all above listed Nuvance Health workforce members including but not limited to the following locations:

☒All of the below entities

☐Nuvance Health Systems

| | | |
|---|---|---|
| ☐ Danbury Hospital (including New Milford Hospital Campus) | ☐ Health Quest Systems, Inc. "(HQSI)" | ☐ Western Connecticut Home Care, Inc ("WCHN") |
| ☐Northern Dutchess Hospital | ☐ Health Quest Home Care, Inc | ☐ Western Connecticut Health Network Physician Hospital Organization ACO, Inc. |
| ☐Norwalk Hospital | ☐ Hudson Valley Cardiovascular Practice, P.C. (aka The Heart Center) ("HVCP") | ☐Western Connecticut Home Care, Inc |
| ☐ Putnam Hospital | ☐ Other HQSI-affiliated Entities Not Listed | ☐ Other WCHN-affiliated Entities Not Listed |
| ☐Sharon Hospital | | ☐Nuvance Health Medical Practices (NHMP PC, NHMP CT, ENYMS & HVCP) |
| ☐Vassar Brothers Medical Center | | |

## POLICY STATEMENT/PURPOSE

To establish guidelines for honoring patient requests to restrict the use and disclosure of their Protected Health Information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

## DEFINITIONS

**Nuvance Health:** For purposes of this policy only, Nuvance Health means entities within the Nuvance Health and its subsidiaries that provide health care and are covered by the HIPAA Privacy Rule.

**Covered Individual:** This term refers to all Nuvance Health workforce members, business affiliates, and agents. Workforce members shall include any of the following individuals at Nuvance Health: Members of the Nuvance Health Board and the boards of any Nuvance Health related entity; President/Chief Executive Officer; administrators; managers, officers; employees, affiliates; medical staff members; appointees; volunteers; personnel; interns; students, trainees, and any individual whose conduct is under direct control of Nuvance Health whether or not they are paid by Nuvance Health. Business Affiliates shall include any non-workforce member, contractor, independent contractor, vendor, person, subcontractor or third-party, who or that, in acting on behalf of Nuvance Health: (i) delivers, furnishes, prescribes, directs, orders, authorizes, or otherwise provides Federal healthcare program items and services; (ii) performs billing or coding functions; (iii) contributes to Nuvance Health's entitlement to payment under Federal healthcare programs; and (iv) is affected by one or more of Nuvance Health's risk areas through the Business Affiliate's interaction with, or performance of their role, functions, and responsibilities or provision of contracted services at Nuvance Health. Agents include

individuals or entities that have entered an agency relationship with Nuvance Health. Agents fall under the category of either Workforce Member or Business Affiliate depending on their role, functions, and responsibilities.

**Health Plan**: An individual or group plan that provides or pays the cost of medical care.

## POLICY

Nuvance Health recognizes that patients can request restrictions on certain uses and disclosures of their PHI, such as limiting the information shared with family members or friends. While Nuvance Health is not required to agree to the requested restrictions, we must comply with a request not to disclose information to a health plan if the patient has paid for the service out of pocket in full.

## PROCEDURE

1. **Submitting a Request**
   a. A covered entity is under no obligation to agree to requests for restrictions. A covered entity that does agree must comply with the agreed restrictions, except for purposes of treating the individual in a medical emergency.
   b. Utilizing the "Patient Request for Restriction of Protected Health Information (PHI)" (see attached), patients may request restrictions on the use and disclosure of their PHI by submitting a written request to the Nuvance Health Chief Compliance, Audit & Privacy Officer or their designee. The request must specify:
      i. the information to be restricted;
      ii. whether the request is to limit use, disclosure, or both; and
      iii. to whom the limits apply.
   c. The request must:
      i. be reviewed to ensure it is fully and accurately completed;
      ii. that the requestor can produce photo ID to verify identity; and
      iii. that appropriate signatures are evident on the form.
2. **Assessment of Requests**
   a. The Nuvance Health Chief Compliance, Audit & Privacy Officer or their designee will review each request to determine its feasibility and compliance with legal and ethical standards.
   b. Requests specifically pertaining to non-disclosure of PHI to a health plan for a service paid out-of-pocket in full by the patient ("self-pay privacy") will be granted automatically in compliance with **45 CFR §164.522(a)(1)(vi).**
3. **Response to Patient**
   a. The organization will notify the patient in writing of its decision. If the request is accepted, the notification will specify any alterations to treatment or operational processes resulting from the restriction.
   b. If the request is denied, the notification will explain the reason for denial and inform the patient of their right to submit a written statement of disagreement.
4. **Documentation**
   a. All decisions regarding restriction requests will be documented in the patient's health record, including details of the agreed restrictions and any subsequent modifications or revocations.
5. **Implementation**
   a. For approved restrictions, all relevant staff members will be informed of the specifics of the restriction, and systems will be updated to flag the restricted PHI appropriately.
6. **Revocation of Restrictions**
   a. Patients may revoke their request for restrictions at any time by providing a written notice to the Nuvance Health Chief Compliance, Audit & Privacy Officer or their designee. Upon receipt, the revocation will be implemented promptly and documented in the patient's health record.

7. **Training**
   a. All staff handling PHI will be trained on this policy and the procedures for managing requests for restrictions, including updates and changes to the policy.

## REFERENCES

**Federal Law:**

| | |
|---|---|
| 45 CFR § 164.502(c) | Standard: Uses and disclosures of protected health information subject to an agreed upon restriction. |
| 45 CFR § 164.510(b) | Standard: Uses and disclosures for involvement in the individual's care and notification purposes |
| 45 CFR § 512 | Uses and disclosures for which an authorization or opportunity to agree or object is not required. |
| 45 CFR § 164.522 | Rights to request privacy protection for protected health information. |
| 45 CFR §164.522 (a)(1)(vi) | (vi) A covered entity must agree to the request of an individual to restrict disclosure of protected health information about the individual to a health plan if:<br><br>(A) The disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and<br><br>(B) The protected health information pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full. |

## SUPERSEDED

**This policy combines and supersedes the following LWCHN and LHQ policies and procedures:**

1. Protected Health Information - A Patient's Right to Request Restrictions on the Use and Disclosure of PHI - Last reviewed LWCHN = 05/24/2024
2. Patient Rights - Request Restrictions on the Use and Disclosure of PHI - Out of Pocket Payment - Health Plan Providers - Last reviewed LWCHN = 05/21/2024
3. Patient Right to Request Privacy Protection for Protected Health Information Policy - Last reviewed LHQ = 07/28/2023
4. Patient Right to Request Privacy Protection for Protected Health Information Procedure - Last reviewed LHQ = 07/28/2023

## APPROVAL

DocuSigned by:
Jared B Gaynor
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**Signature**

7/17/2024

**Date**

Original Effective Date: 07/17/2024
Revision Dates: see "Supersedes" section for details
Latest Review: 07/17/2024
Originator: Corporate Compliance
Approved by: Executive Leader

# Patient Request for Restriction of Protected Health Information (PHI)

**Instructions for Submission:**

Please complete all sections of this form and sign below.

Return this completed form to the Nuvance Health Chief Compliance, Audit & Privacy Officer at the following address:

Wayne McNulty, Chief Compliance, Audit & Privacy Officer
Nuvance Health
100 Reserve Road
Danbury, CT 06810

Alternatively, you may submit this form via email at Compliance@nuvancehealth.org

## Patient Information

Name: _____

Date of Birth: _____

Patient ID (if applicable): _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Email Address (optional): _____

## Request Details

1. **Specific Information to Restrict:**
   Describe the specific health information you want to restrict (e.g., specific medical records, treatment dates, types of treatment, etc.).

   _____

2. **Type of Restriction Requested:**
   - [ ] Do not use the information
   - [ ] Do not disclose the information
   - [ ] Both use and disclose

3. **Persons/Organizations Restriction Applies To:**
   Specify the individuals, organizations, or classes of persons to whom the restriction applies.

   _____

4. **Duration of the Restriction:**

   _____

5. **Indicate how long you want the restriction to apply.**

_____

6. **Reason for the Restriction (optional):**
While you are not required to state a reason, doing so may help the facility better understand your needs.

_____

7. **Self-Pay Privacy Restriction**
[ ] Check here if this restriction involves a service for which you have paid out of pocket in full and you do not want the information disclosed to your health insurance plan.

**Signature**

I understand that this request for restrictions will be applied only after it is formally approved and that I will be notified in writing of the decision. I also understand that the healthcare provider may not agree to the restriction, except in the case of disclosures to a health plan for services that are self-paid in full as stated above.

| **Patient** | **Witness** |
|---|---|
| Signature: _____ | Name (print): _____ |
| Date: _____ | Signature: _____ |
| | Date: _____ |

| **For Facility Use Only** - ***Note: This form is to be place in the patient's medical record, with a copy to the billing department (if applicable).*** | |
|---|---|
| Received by: _____ Date: _____ | |
| Reviewed by (print):<br>Signature:<br>Date: | _____<br><br>_____ |
| Decision: | [ ] Approved<br>[ ] Denied (provide reason): _____ |