Washington University in St. Louis

HIPAA Privacy Procedure #16

Requests for

Restrictions on Use or Disclosure and Alternative Methods of Communication of Protected Health Information

Effective Date: April 14, 2003
Reviewed Date: February, 2011
Revised Date: February, 2011
Scope: Radiation Oncology

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Policy Expectation:

Individuals have the right to request restrictions on the Use or Disclosure of their Protected Health Information (PHI) for purposes of Treatment, Payment or Health Care Operations or on Disclosures made to persons involved in the Individual's care. Individuals also have the right to request how Radiation Oncology will communicate with them concerning their PHI. This Procedure addresses how requests for restrictions on the Use or Disclosure of PHI and the communication of PHI will be processed and how RO will respond to such requests.

Examples of such requests include:

- Individual requests that his social security number be deleted from all records Used or Disclosed by RO.
- Individual desires all future communication that would be made to his home address by mail, phone, fax or e-mail be redirected to his business location as he does not want his family to know about his recent diagnoses.
- Individual presents as a walk-in at the practice site. After initial assessment, he is found to be intoxicated. Individual requests that the fact of intoxication not be mentioned in the recordings of the current visit.
- Individual requests that certain members of our workforce be denied access to their records

Why is this important?

- Compliance with all HIPAA privacy regulations is required of all Radiation Oncology Divisions creating, collecting or holding PHI on behalf of Individuals.
- Failure to comply may result in being liable for civil and criminal penalties.

What do you need?

- Form from the Individual requesting a restriction on Use and/or Disclosure of PHI.
- Form from Individual requesting alternative means or locations to receive confidential communication(s) of PHI.
- Understanding that for all forms, the wording "*completing this form does not constitute agreement of the requested restriction or alternative means for communication*" must be clearly and simply stated.

To Restrict Uses and Disclosures:	Additional Information
Radiation Oncology medical records are owned by Barnes-Jewish Hospital. Direct all requests made in person or by telephone to BJH. Requests in writing may be responded to with the appropriate BJH form to complete. Requests should not be sent to the WU Privacy Officer or the WU Radiation Oncology Privacy Liaison.	BJH Medical Record Room: David Rey, Tel 362-1913

To Request Alternative Means of Communication:	Additional Information
1. Upon verbal request from an Individual for an alternative means of communication of confidential information, guide the individual through completion of the appropriate form.	See Exhibit A
2. Make no promises. Emphasize Radiation Oncology will seriously consider the request in light of necessary business operations. Tell the Individual also that the response may take up to 60 days, depending upon how many departments are affected.	
3. FAX the form to the Radiation Oncology Privacy Liaison.	RO Privacy Liaison Kevin Sharkey Tel 314-286-1076 FAX 314-362-8521 Campus Box 8224 mailto:ksharkey@radonc.wustl.edu
4. The Radiation Oncology Privacy Liaison will FAX the form to the Hospital Privacy Office.	
5. RO Privacy Liaison will forward a copy of the completed form to BJH Medical Records Custodian to file in the medical record.	
6. Each activity will be logged by the RO Privacy Liaison.	

EXHIBIT A

Request for Alternative Methods of Confidential Communications

Washington University will accept for review written requests for alternative means or locations for you to receive confidential communications of your Protected Health Information ("PHI"), such as lab results or other related information. Washington University will accommodate reasonable requests for alternative means or locations, provided that it receives accurate information concerning how you will handle payment for patient services, how it may contact you (or your personal representative), and whether the alternative designated will be administratively difficult for Washington University to follow.

Request Date: _____
Individual Name: _____

Date of Birth: _____ SSN: _____

Individual Address:_____

Telephone Number: (H)_____ (W)_____

1. For communications of PHI, please make all contacts as follows:
(complete only the acceptable method(s) of communication)

   By U.S. Mail at the following address: _____
   _____

   By Telephone at: ( ) _____

   By Email at:_____

   Other Alternative Means: _____

2. Payment information should be sent to: _____
(Must be completed to process request) _____

3. For other questions, you may contact me at: (____)_____

For Health Plans Communications Only: Please provide an explanation concerning the reason for your request for alternative means or locations for confidential communications. You must provide a reason that the disclosure of all or part of your PHI could endanger you._____
_____
_____

_____

Signature of Individual or Personal Representative Date

For Washington University Use Only:
Date of Response:_____

_____ Request Agreed Upon

_____ Request Denied

Signature of Staff Person _____ Date _____

Print Name & Title_____ _____