Wood County Employee Health Benefits Plan

NOTICE OF PRIVACY PRACTICES

Effective 4/14/04 Revised 9/23/13

The Wood County Employee Health Benefits Plan (Plan) has adopted the following practices and procedures with respect to the use and protection of your individual Protected Health Information (PHI). This notification is required by the Health Insurance Portability and Accountability Act (HIPAA).

This Notice describes how your medical information may be used and disclosed. It also describes how you can access this information. "Protected health information" (PHI) is individually identifiable health information, including demographic information, collected from a covered individual, created, maintained or received by a health care provider, a health plan, the employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or conditions; (ii) the provision of health care to persons covered under the plan; or (iii) past, present, or future payment for the provision of health care to covered individuals, whether in writing, in electronic format or as an oral communication.

HIPPA law requires the Plan to maintain the privacy of health information of covered employees and family members, provide them with notice of the legal duties and privacy practices with respect to Protected Health Information and follow the practices described herein. These rules apply to the health benefits Plan, not Wood County as an employer. PHI will not be shared from the Plan to the employer for any employment related action.

The Plan reserves the right to change privacy practices and the terms of this Notice at any time. All material revisions to this Notice will be provided through a revised copy. This Notice and any revisions are available on the county website at www.co.wood.oh.us/employee or may be obtained by contacting the Privacy Officer below.

All questions regarding this notice may be addressed to the designated County Privacy Officer: Pamela Boyer, Human Resources and Benefits Manager, who may be reached through the Commissioners' Office at 419-354-9100.

Common Permitted Disclosures and Uses of Protected Health Information

The Plan is committed to maintaining the confidentiality of health information of employees and family members covered by its Plan. PHI of employees and family members covered by the Plan may be used and disclosed for purposes set forth below. Use of PHI for other purposes requires a signed authorization from the covered individual, unless the law permits or requires us to use or disclose the PHI without authorization. Covered members may revoke their authorization, in writing, except if the Plan has already acted basedon their member's authorization. Where Ohio law imposes greater restrictions on disclosure than the federal laws and regulations protecting the privacy of health information, the Plan will comply with Ohio law.

A. **Third-Party Administrator Disclosure**: As a self-insured plan, the Plan receives, maintains and stores PHI. It may disclose PHI to our Third Party Administrator(s) to assist Wood County in administering the health, prescription, vision and dental and life Plans. Wood County is not permitted to use the PHI for any purposes other than as required for administration purposes.

B. **Treatment, Payment, and Healthcare Operations Disclosure**: Except as otherwise provided, the Plan may disclose PHI for purposes of enrollment, treatment, payment, and as otherwise permitted by law, for operation of the Plan. This may include disclosure to another health care provider, such as a physician, a case manager, or medical reviewer who is involved in your treatment. The Plan may also disclose for purposes of approval of reimbursement from the Plan or disclosure for audit purposes, customer service, appeals, stop loss or use in coordinating benefits.

C. **Business Associates Disclosure**: The Plan may be required to disclose PHI to certain outside persons or entities that assist with the healthcare operations, such as auditing, accreditation, stop loss, risk-management, consultants, legal services, etc. These business associates are required to safeguard the privacy of any health information and require their sub-contractors to do the same.

D. **Treatment Alternatives and Case Management**: Wood County may contact covered individuals to provide treatment alternatives and other health-related benefits that may be of interest.

E. **Other Uses and Disclosures of Protected Health Information:** Wood County may use or disclose medical information about employees and covered family members without prior authorization for the reasons listed below:

1. public health purposes;
2. accrediting organizations;
3. required abuse or neglect reporting;
4. health oversight audits or inspections;
5. authorized research studies;
6. coroner or funeral arrangements;
7. organ donations;
8. others involved in your care;
9. military and national security protective services;
10. correctional institutions;
11. workers' compensation purposes;
12. upon request from law enforcement in specific circumstances;
13. in response to valid judicial or administrative orders;
14. as required by federal law;
15. emergencies or disaster relief efforts such as serious threat to health and safety.

The plan will limit the amount of PHI used to the minimum necessary to accomplish the intended purpose. Genetic information may not be used for underwriting purposes. Sale of PHI is prohibited and it shall not be used for marketing. The Plan or its Business Associates will notify you if it becomes aware that there has been a breach of PHI as required by law.

Employee and Family Member Rights Regarding Protected Health Information

Employees and family members covered under the Plan may make the requests listed below. The requests must be in writing and signed by the individual making the request or his/her representative. Forms with additional information on the process may be obtained on the website at www.woodcountyohio.gov or by contacting the Privacy Officer: Pamela Boyer, Human Resources and Benefits Manager, Wood County Commissioners' Office, One Courthouse Square, Bowling Green, Ohio 43402, by phone at 419-354-9100, or email at pboyer@woodcountyohio.gov.

A. **Restrictions on Use and Disclosure of Individual Health Information**. Persons covered under the Plan have the right to request that Wood County restrict use and disclosure of personal health information. The Plan is not required to agree to requested restrictions and if granted, may terminate restriction later by providing written notification. The Plan cannot agree to limit uses/disclosures that are required by law or if the patient pays for services completely out of pocket.

B. **Access or Copying Your Health Information**. Employees and family members covered under the Plan have the right to request to inspect or copy in a "designated record set" their health information, except psychotherapy notes. If copies are requested, the Plan may charge a fee for the cost of copying, mailing or other related supplies. Depending on the circumstances, the right to review may be denied. If the Plan denies a request, the person making the request will be given a written notice that will explain the basis of the denial and the right to appeal.

C. **Amendments to Individual Health Information**. Employees and family members covered under the Plan have the right to request that their inaccurate or incomplete health information be amended or corrected. The written request must state the reasons for the amendment. In certain cases, the Plan may deny the request for amendment. If so, a written notice will explain the basis of the denial and the right to appeal. The requestor may also submit a statement of disagreement to the denial. If the Plan makes an amendment, they may notify others who have copies of the amended record, if such notification is necessary.

D. **Accounting for Disclosure of Individual Health Information**. Employees and family members covered under the Plan have the right to receive an accounting of certain disclosures of their health information made up to six years prior to the request.

E. **Confidential Communications**. Employees and family members covered under the Plan have the right to request that medical information be communicated in a confidential manner, such as mailing to an address other than their home by specifying the type of communication or alternate address and a statement that disclosure of all or part of information could endanger you.

How to File a Complaint About Wood County's Privacy Practices

If an employee or a family member covered under the Plan believes that the Plan may have violated these privacy rights, or disagrees with a decision regarding access to PHI, he/she may file a written complaint with our Privacy Officer: Pamela Boyer at 419-354-9100. A written complaint may also be filed with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, SW, Washington D.C. 20201 or call 1-877-696-6775. Complaints filed directly with the Secretary must: 1) be in writing; 2) contain the name of the entity against which the complaint is lodged; 3) describe the relevant problems; and 4) be filed within 180 days of the time the individual became or should have become aware of the problem. There will be no retaliation for filing a complaint.

Authorized by Trustees of the Plan: 8/12/04

Date Last Revised: 9/23/13

Wood County Employee Health Benefits Plan HIPAA Compliance

Request for Amendment of Protected Health Information

Individual's Name: _____

Group Health Plan ID No.:_____ SubGroup No.:_____

Address: _____

Work Phone: _____ Home Phone: _____

Conditions Governing the Request for an Amendment

Under the Standards for the Privacy of Individually Identifiable Health Information (often called the "Privacy Rule"), the Wood County Employee Health Benefits Plan (Plan) and its Business Associates must permit a individual to request an amendment of his/her protected health information that he/she believes is inaccurate or incomplete.

The Plan may deny an individual's request if the protected health information:

1. Is not part of a designated record set (Under the Privacy Rule, a designated record set is a group of records maintained by the Plan and its Business Associates that are the medical records and billing records about individuals maintained by or for the Plan and any other records that may be used to make health care decisions about individuals);
2. Was not created by the Plan or its Business Associate(s);
3. Is complete and accurate;
4. Constitutes psychotherapy notes;
5. Was compiled in anticipation of or for use in any civil, criminal, or administrative action or proceeding involving the Plan; or
6. Is not subject to disclosure to the individual under the Clinical Laboratory Improvements Amendments of 1988.

Nature of Request for Amendment

I wish my Plan to amend the following protected health information: _____

_____

I request this amendment for the following reason(s): _____

_____

The information should be amended as follows: _____

_____

I want my Plan to notify the following persons who may have received my protected health information in the past of any amendment to my protected health information: _____

_____

I agree that my Plan may provide my amended protected health information to Business Associates: (i) that the Plan has provided the protected health information, which is the subject of the amendment request, and (ii) from whom the Plan has received the protected health information, which is the subject of the amendment request: ☐ Yes ☐ No

Signature: _____ **Date:** _____

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to the Individual: _____

Plan/Business Associate to Complete the Following:

Response to Request for an Amendment

The Plan must respond to an individual's amendment request within 60 days.

Date of receipt of request: _____/_____/_____

If necessary, the Plan may take one 30-day extension from the date of receipt of the request to provide a response.

Extension notice sent on: _____/_____/_____

Response date promised in extension notice: _____/_____/_____

Reason given for extension: _____

Review of Request for Amendment

Request for correction / amendment has been: ☐ Accepted ☐ Denied

Request for Amendment Is Accepted

Date the individual notified of the acceptance of the request: _____/_____/_____

Date the persons or entities identified by the individual to receive the amended protected health information were notified of the amendment: _____/_____/_____

Date that the appropriate Business Associates were notified of the amendment: _____/_____/_____

Request for Amendment Is Denied

The request for amendment was denied for the following reasons:

- ☐ The protected health information was not created by the Plan or its Business Associate(s).
- ☐ The protected health information is not part of a designated record set.
- ☐ The protected health information constitutes psychotherapy notes.
- ☐ The protected health information is accurate and complete.
- ☐ The protected health information is compiled in anticipation of, or for use in, any civil, criminal, or administrative action or proceeding in which the Plan is involved.
- ☐ The protected health information is not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988.

The individual was notified of the denial on: _____/_____/_____

Objection to Denial of Request for Amendment

On _____/____/_____ the individual requested that the request for amendment and the Plan's denial be included in future disclosures of the protected health information. The Plan will link or append the request for amendment and the Plan's denial of the request to the disputed protected health information, and include the request for amendment and the Plan's denial of request, or, in the alternative, a summary of the facts for future disclosures of the disputed protected health information.

On _____/_____/_____ the individual submitted a statement of disagreement. The Plan will link or append the statement of disagreement to the disputed protected health information and include the statement of disagreement, the request for amendment, and the denial of the request, or, in the alternative a summary of the facts for future disclosures of the disputed protected health information.

On _____/_____/_____ the Plan prepared a rebuttal to the individual's statement of disagreement and sent it to the individual. The Plan will link or append the rebuttal statement to the disputed protected health information and include the statement of disagreement, the request for amendment, the denial of the request, and, the rebuttal, or, in the alternative a summary of the facts for future disclosures of the disputed protected health information (insert text here.)

_____ _____

Signature of Plan/Business Associate Representative **Date**

cc: Employee or Designated Rep.
Applicable BA, file

Wood County Employee Health Benefits Plan HIPAA Compliance

Request for Access to Protected Health Information

Individual's Name: _____

Group Health Plan ID No.: _____ SubGroup No.:_____

Address: _____

Work Phone: _____ Home Phone: _____

Conditions Governing the Request for Access

The individual named in this request agrees that the Request for Access herein is subject to the following conditions.

1. Under the Standards for the Privacy of Individually Identifiable Health Information (often called the "Privacy Rule"), the Wood County Employee Health Benefits Plan (Plan) and its Business Associates must permit an individual to inspect and obtain a copy of his/her protected health information that the Plan and its Business Associates maintain in a "designated record set." A "designated record set" is a group of records maintained by the Plan and it's Business Associates that are the medical records and billing records about individuals maintained by or for the Plan and any other records that may be used to make health care decisions about individuals enrollment, payment, claim adjudication, and case or medical management.
2. The individual is not entitled to inspect or obtain the following records, even if in a designated record set: copies of any psychotherapy notes; any information complied in anticipation of or for use in any civil, criminal, or administrative proceeding.
3. There is no charge to inspect an individual's records on the Plan's premises or for available electronic transmission.
4. The individual will be charged $0.10 per page for any copies of Protected Health Information and postage if copies are to be mailed to the individual. The Plan will notify the individual of the amount due and will collect the costs before the Plan processes the request. If the individual chooses not to pay the charge, the request for access will be cancelled.

Nature of Request for Access

I wish to ☐ **inspect** ☐ **have a copy of the following protected health information**:

☐ My enrollment records ☐ My payment records

☐ My claims adjudication records ☐ My case or medical management records

☐ Any other protected health information used by my Group Health Plan ("Plan") to make medical decisions about me. Please describe. _____

I wish to receive a copy of the requested protected health information in the following format:

☐ Photocopies ☐ Electronic transmission (if available) ☐ Other (if available) _____

In lieu of inspecting or obtaining a copy of my protected health information, I would prefer to receive the requested information in the form of a summary prepared by my Plan at a cost to me of [$ _____] ☐ Yes ☐ No The summary will describe: _____

In addition to inspecting and/or obtaining a copy of my protected health information, I request that my Plan prepare an explanation of the requested protected health information at a cost to me of [$ _____] ☐ Yes ☐ No

I want you to mail the copies of my protected health information, a summary of my protected health information, and/or an explanation of my protected health information to the following address:

_____

Signature: _____ **Date:** _____

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to the Individual: _____

Plan/Business Associate to Complete the Following:

Response to Request for Access

The Plan must respond to an access request within 30 days of its receipt. If the requested records are off site, the Plan must respond within 60 days.

Date access request received: ____/____/____

Date appropriate the Plan units and business associates directed to search for requested records: ____/____/____

The Plan may take one 30-day extension by notifying the individual in writing within the 30 or 60-day response period of the reason for the extension and the date on which the Plan will provide its response:

Extension notice sent on: ____/____/____ Response date promised in extension notice: ____/____/____

Reason given for extension: _____

Review of Request for Access

The request for access has been reviewed by Plan/Business Associate and is: ☐ Accepted ☐ Denied

Request for Access Granted

Access granted on: ____/____/____ and notice of granted request for access sent to individual.

Records inspected: ____/____/____

Copies supplied: ____/____/____ Charges: $_____ Paid: ____/____/____

Summary or explanation provided: ____/____/____ Charges: $_____ Paid: ____/____/____

Denial of Request for Access

The request has been denied for one of the following ***unreviewable*** reasons:

- ☐ Protected health information is not part of the designated record set.
- ☐ The requested information is not maintained by the Plan or its Business Associate(s).
- ☐ Federal law forbids making the requested information available to the individual for inspection (e.g., CLIA or Privacy Act of 1974).
- ☐ The requested information is psychotherapy notes.
- ☐ The requested information has been compiled for legal proceeding in which the Plan is involved.
- ☐ The requested information was obtained from someone other than a health care provider under promise of confidentiality and access would be reasonably likely to reveal the source of the information.
- ☐ The requested information is temporarily unavailable because the individual is a research participant.
- ☐ Unable to provide summary of records. Actual records are provided.

The request has been denied for one of the following ***reviewable*** reasons:

- ☐ A licensed health care provider has determined that access to the requested information would result in physical harm to the individual or others.
- ☐ A licensed health care provider has determined that the requested information identifies a third person who is not a health care provider and that substantial harm is reasonably likely to occur if access to the information is granted.
- ☐ A licensed health care provider has determined that access to the requested information by the individual's legal representative could result in harm to the individual.

Review of A Denial of Request for Access

Individual requested a review of the Plan's denial of access on: _____/_____/_____

A licensed health care professional examined the individual's request for review of a denial of access on: ____/_____/_____

Result of the review is attached ☐ Yes ☐ No

_____ _____

Signature of Plan/Business Associate Representative **Date**

cc: Employee or Designated Rep.
Applicable BA, file

Wood County Employees' Health Benefits Plan HIPAA Compliance

Request for an Accounting of Certain Disclosures of Protected Health Information

Individual's Name: _____

Group Health Plan ID No.: _____ SubGroup No.: _____

Address: _____

Work Phone: _____ Home Phone: _____

Conditions Governing the Request for an Accounting

The individual making this request agrees to the following conditions.

1. The Privacy Rule which requires certain disclosure of protected health information to the individuals who request an accounting ***does not*** require the Plan to account for the following disclosures:
   a. Disclosures made up to six years prior to date of request;
   b. Disclosures made for purposes of carrying out treatment, payment or health care operations;
   c. Disclosures made to the individual regarding his/her protected health information or your respresentative;
   d. Disclosures made for national security or intelligence purposes;
   e. Disclosures made to correctional institutions or law enforcement officials;
   f. Disclosures made pursuant to an authorization from the individual or his/her personal representative;
   g. Incidental disclosures made pursuant to the Privacy Rule; or
   h. Disclosures made as part of a "limited data set" (as defined by the Privacy Rule).
2. The Plan may temporarily suspend the individual's right to receive an accounting of disclosures the Plan has made to a health oversight agency or a law enforcement official, if the agency or official has informed the Plan that such an accounting would be reasonably likely to impede the activities of such agency or official.
3. The individual is entitled to one free accounting for each twelve (12) month period. For any additional accounting requested within the same twelve (12) month period, the Plan may charge a reasonable fee for copy costs and mailing fees. If facility charges a fee for copy and/or mailing costs, the individual will be provided an estimate of and must pay such cost prior to receiving the accounting. If the individual chooses not to pay such costs, the request will be deemed cancelled.

Nature of Request for an Accounting of Certain Disclosures

I hereby request to receive an accounting of all disclosures made of my protected health information for reasons other than those expressly excluded from this accounting requirement by the Standards for the Privacy of Individually Identifiable Health Information (often called the "Privacy Rule").

(CHECK ONE):

☐ All disclosures (that are not excluded) made during the (6) six-year period prior to the date of this request.

☐ All disclosures (that are not excluded) made during the following time period:

____/____/____ through ____/____/____ (not to include disclosures made before 4/14/04.)

Signature: _____ **Date:** _____

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to the Individual: _____

Plan/Business Associate to Complete the Following:

Response to Request for Accounting

The Plan must respond to an individual's accounting request within 60 days of receipt.

Date accounting request received: ____/____/____

Accounting Period: From ____/____/____ To ____/____/____

If necessary, the Plan may take one 30-day extension from the date of receipt of the request to provide a response.

Extension notice sent on: ____/____/____

Response date promised in extension notice: ____/____/____

Reason given for extension: _____

Individual's right to receive an accounting of disclosures made to a health oversight agency or law enforcement official is temporarily suspended pursuant to the written notification received by the Plan from the agency or official. The suspension period expires on: _____/_____/_____.

If one accounting has been provided previously within the same twelve (12) month period, an estimate of the charge, if any, for copying and mailing may be used for the new request.

Date estimated charge communicated to individual: _____/_____/_____

Date individual ☐ accepted ☐ rejected charge: _____/_____/_____

Date accounting sent to member: _____/_____/_____

Request for Accounting Is Denied:

The request for accounting is denied for the following reason(s)

- ☐ Disclosures are greater than six years prior to request;
- ☐ Disclosures made for purposes of carrying out payment or health care operations;
- ☐ Disclosures made to individual regarding his/her protected health information;
- ☐ Disclosures made for national security or intelligence purposes;
- ☐ Disclosures made to correctional institutions or law enforcement officials;
- ☐ Disclosures made pursuant to an authorization from the individual or my personal representative;
- ☐ Incidental disclosures made pursuant to the Privacy Rule; or
- ☐ Disclosures made as part of a "limited data set" (as defined by the Privacy Rule).

The individual was notified of the denial on: _____/_____/_____

_____ _____

Signature of Plan/Business Associate Representative **Date**

cc: Employee or Designated Rep.
Applicable BA
file

Wood County Employee Health Benefits Plan HIPAA Compliance

Complaint Form

This form shall be used if you believe that the Wood County Employee Health Benefits Plan ("Plan") has failed to comply with matters covered in its Notice of Privacy Practices or with the privacy policies as required by Standards for the Privacy of Individually Identifiable Health Information (often called the "Privacy Rule"). The Plan will not penalize or retaliate against you for filing a complaint.

Individual's Name: _____

Group Health Plan ID No.: _____ SubGroup No.: _____

Address: _____

Work Phone: _____ Home Phone: _____

Complaint

What is the nature of your complaint? (Please describe the reasons for your complaint in as much detail as you can provide. For example, which provision in the Privacy Notice you believe that the Plan has violated and how the Plan may have committed the violation. Attach additional pages if necessary.)

When did the action causing the violation occur?

If relevant, identify any persons at the Plan's organization that may have information about your complaint.

Upon completion of this form, please return it to:

Human Resources and Benefits Manager
Commissioners' Office
One Courthouse Square
Bowling Green, Ohio 43402

If you have any questions about this form or matters covered in the Plan's Notice of Privacy Practices, please contact the Plan's Privacy Officer at the above address or at 419-354-9100**.**

You certify that the statements made in this complaint are true and correct to the best of your information and belief.

Signature: _____ **Date:** _____

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to the Individual: _____

_____ _____

Signature of Plan/Business Associate Representative **Date**

Wood County Employee Health Benefits Plan HIPAA Compliance

Request for Confidential Communications

Individual's Name: _____

Group Health Plan ID No.: _____ SubGroup No.: _____

Address: _____

Work Phone: _____ Home Phone: _____

Conditions Governing the Request for Confidential Communications

Under the Standards for the Privacy of Individually Identifiable Health Information (often called the "Privacy Rule"), the Wood County Employee Health Benefits Plan (Plan) and its Business Associate(s) must honor *reasonable* Requests for Confidential Communications if a disclosure of protected health information could endanger the individual covered by the Plan.

Nature of Requested Restriction

A. I represent that I could be endangered if my Plan fails to communicate my protected health information by an alternative means or at an alternative location. _____ [Please initial.]

B. I request my Plan or its Business Associate(s) to communicate with me regarding my protected health information in the following alternative manner or method.

- ☐ At a telephone number other than my home number. The telephone number at which I should be contacted is: _____
- ☐ At a mailing address other than my home mailing address. The mailing address at which I should be contacted is: _____
- ☐ Through my e-mail address, rather than my home address. My e-mail address for purpose of contacting me is: _____
- ☐ Other. Please specify: _____

Signature: _____ **Date:** _____

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to the Individual: _____

Plan/Business Associate to Complete the Following:

Response to Request for Confidential Communications

The Request for Confidential Communications has been reviewed by the Plan/Business Associate and is:

☐ Accepted* ☐ Denied (Request cannot reasonably be accommodated)

* If Request is accepted in part, describe the restriction to be implemented: _____

Date Restriction Becomes Effective: _____/_____/_____

Comments: _____

_____ _____

Signature of Plan/Business Associate Representative Date

cc: Employee or Designated Rep, Applicable BA, file

Wood County Employee Health Benefits Plan HIPAA Compliance

Request for Restrictions on Use or Disclosure of Protected Health Information

Individual's Name: _____

Group Health Plan ID No. _____ SubGroup No._____

Address: _____

Work Phone: _____ Home Phone: _____

Conditions Governing the Request for Restrictions

The individual named in this request agrees that the request is subject to the following conditions.

1. Under the Standards for the Privacy of Individually Identifiable Health Information (often called the "Privacy Rule"), the Wood County Employee Health Benefits Plan (Plan) and its Business Associate(s) are not required to agree to this Request for Restriction, or they may agree to only a part of the Request for Restriction, while denying agreement to the remaining request.
2. If the Plan or Business Associate(s) agree to the requested restriction (whether all or in part), the restriction is in effect until one of the following events occurs:
   a. Individual agrees to or requests in writing that the restriction be terminated; or
   b. The Plan or Business Associate(s) notifies the individual that it is terminating the agreement to restrict the uses and/or disclosures of protected health information.
3. If an individual terminates a restriction, the individual's protected health information will no longer be subject to the restriction. If the Plan or Business Associate terminates the agreement to restrict, the termination is effective only with respect to information created or received after the date of termination of the restriction.
4. If the Plan/Business Associate(s) agrees to a request for restriction, restricted protected health information still may be disclosed to provide emergency treatment, with no further use or disclosure for any other purpose.
5. Individual has a right to access protected health information during the restriction as allowed under the Privacy Rule and any other applicable law.
6. Individual may receive an accounting of certain disclosures of protected health information as explained in the Plan's Notice of Privacy Practices.
7. Protected health information may still be disclosed for public policy purposes as stated in the Notice of Privacy Practices.

Nature of Requested Restriction

I request my Plan or its Business Associate(s) to restrict the use and/or disclosure of the following protected health information:

Restrict uses and/or disclosures of protected health information for purposes of payment or health care operations in the following manner:

_____

_____

(e.g., do not use my protected health information to audit the Plan's preferred providers)

Restrict disclosures to a family member, relative, or close personal friend who is involved with my health care. Please specify individual(s) to whom this restriction applies:

_____

_____

Signature: _____ **Date:** _____

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to the Individual: _____

Plan/Business Associate to Complete the Following

The Request for Restriction is: ____ Accepted* _____ Denied

* If Request is accepted in part, describe the restriction to be implemented:

_____

Date Restriction Becomes Effective: ____/____/____

_____ _____

Signature of Plan/Business Associate Representative **Date**

cc: Employee or Designated Rep.
Applicable BA
file