Weber Family Chiropractic PC
Patient Right to Request Restrictions on Use and Disclosure of Health Information

Policy No.: 6

Issue Date: 04/14/03 Revision Date: ___/___/___

Approvals: Dr. Scott Weber ____________________________________
Title: Office Manager Title:

I. POLICY

It is the policy of Weber Family Chiropractic PC to allow a patient or the patient's authorized representative to request restrictions on the use and disclosure of the patient's health information for treatment, payment and health care operations, as well for family notification purposes. Weber Family Chiropractic PC may deny requested restrictions. If Weber Family Chiropractic PC approves the requested restrictions, Weber Family Chiropractic PC will abide by the restrictions, unless the restricted health information is needed by another health care provider to provide emergency care to the patient. This Policy supersedes any previous policy on this subject.

II. PURPOSE

The purpose of this Policy is to outline the procedures to be followed in evaluating and responding to patient requests to restrict the use or disclosure of the patient's health information.

III. SCOPE

This Policy applies any time a request is made to limit the use or disclosure of health information for treatment, payment and health care operations or for family notification purposes. This Policy does not apply to requests for restrictions on uses and disclosures that are required by law. The procedures in this Policy will be used to differentiate between a permitted request and a prohibited request.

IV. PROCEDURES

1. If the patient requests to restrict the use or disclosure of the patient's health information, the receptionist will ask the patient to complete a Request for Restriction of Health Information Form ("Form").

2. The Form may be submitted in person, by mail or by facsimile. If mailed or faxed, the receptionist will instruct the patient to return the completed Form to the attention of Dr. Scott Weber. The receptionist will give all completed Forms to Dr. Scott Weber.

3. Dr. Scott Weber will review the Form to ensure that the Form is complete and has been signed and dated by the patient. If the Form is not complete, Dr. Scott Weber will contact the patient to provide instructions for completion of the Form. The deadlines in this Policy will be calculated from the date of receipt of a completed Form.

4. Dr. Scott Weber will review the Form to determine whether the requested restriction applies to a use or disclosure that is required by law or to a use or disclosure that is needed for treatment by another provider. Any such request is outside of the scope of this Policy. The uses and disclosures that are required by law are listed

in Weber Family Chiropractic PC's Notice of Health Information Practices and in Policy Nos. 2 and 3 (Consent and Authorization Policies).

5. If the request pertains to a use or disclosure that is required by law or a use or disclosure that is needed for treatment by another provider, Dr. Scott Weber will deny the request and send a denial letter (in the form attached to this Policy) to the patient within thirty (30) days after receipt of the completed Form. Dr. Scott Weber will place a copy of the Form (with bottom portion completed) and the denial letter in a file maintained by Dr. Scott Weber specifically for this purpose.

6. If the request is not prohibited under No. 4 above, Dr. Scott Weber will determine whether the request is related to treatment, payment or health care operations or family notification. Uses for treatment, payment and health care operations are defined in the Notice of Health Information Practices and in Policy No. 14 (General Privacy Overview).

7. If the request does apply to treatment, payment or health care operations, Dr. Scott Weber shall consult with the patient's primary practitioner, as well as personnel in charge of medical records, to determine whether the requested restriction can be approved. Factors that may be considered in making this determination include:

a. adverse effect on the patient's care and treatment;

b. adverse effect on the ability of Weber Family Chiropractic PC to coordinate care for the patient;

c. adverse effect on Weber Family Chiropractic PC's ability to bill and /or collect payment for services rendered to the patient;

d. adverse effect on Weber Family Chiropractic PC's ability to carry out its administrative activities;

e. adverse effect on Weber Family Chiropractic PC's ability to comply with state or federal laws or regulatory requirements; and

f. adverse effect on Weber Family Chiropractic PC's ability to obtain necessary consultation (legal, accounting, technical).

All of these factors will be weighed against the benefit to the patient of having the request approved.

8. If Dr. Scott Weber determines that Weber Family Chiropractic PC cannot approve the request, Dr. Scott Weber will follow the steps in No. 5 above.

9. If Dr. Scott Weber determines that Weber Family Chiropractic PC can abide by the restrictions, Dr. Scott Weber will send an approval letter (in the form attached to this Policy) to the patient within thirty (30) working days after receipt of the request. Dr. Scott Weber will place a copy of the approval letter in the patient's medical record in a location that will be noted by all personnel handling the medical record and in the computer database, as appropriate. Dr. Scott Weber will also place a copy of the Form (with bottom portion completed) and the approval letter in the file maintained by Dr. Scott Weber specifically for this purpose. Finally, Dr. Scott

Weber will forward a copy of the Form and approval letter to personnel in charge of medical records, who will keep the copy in a notebook for future reference.

10. Dr. Scott Weber shall ensure that all forms and letters (both denial letters and approval letters) are retained for six (6) years after the date on each document.

11. If the request has been approved, Weber Family Chiropractic PC will abide by the request. Any time that a request for medical records is made by a person outside of Weber Family Chiropractic PC, the request will be forwarded to the personnel in charge of medical records. These personnel will check all Forms and letters maintained in the notebook before disclosing the medical records.

12. Weber Family Chiropractic PC may disclose restricted health information to another health care provider if (a) such restricted health information is necessary to the emergency care and treatment of the patient and (b) Weber Family Chiropractic PC requests that the health care provider not further use or disclose the restricted health information.

13. Weber Family Chiropractic PC may terminate a restriction only as follows:

a. the patient agrees to or requests the termination in writing;

b. the patient orally agrees to the termination and the oral agreement is documented by Dr. Scott Weber; or

c. Dr. Scott Weber notifies the patient in writing that it is terminating the restriction for all health information created or received after the date of the letter.

Weber Family Chiropractic PC

Request for Restriction on Health Information

You (or your authorized representative) have the right to request restrictions on the manner in which your health information is used and/or disclosed by Weber Family Chiropractic PC or others for purposes of treatment, payment or health care operations or notification of family members. Weber Family Chiropractic PC will consider all requests but is not required by law to approve your request. If we agree to the requested restriction, we will abide by the terms of the restriction until such time as the restriction is terminated. Please complete this form and return it to the receptionist or mail or fax it to Weber Family Chiropractic PC to the attention of Dr. Scott Weber. We will inform you in writing of our decision.

Patient Name:____

Home Address:____

Date of Birth:____________________________Home Phone:____________________________

Please describe how you wish to restrict the use of your health information by Weber Family Chiropractic PC for treatment, payment or health care operations or family notification purposes:

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Signature of Patient or Patient's Representative	Date of Request
Print Name of Patient's Representative	Relationship to Patient

OFFICE USE ONLY:

Approve:_____Deny:_______Reason:____

Reviewed By:____Date:_________________________

Patient Notification Date:____(Attach letter)

Copy filed: ______Medical Chart ______Office File ______Medical Records Department

Change Made: ______ Computer Database ______Billing Record