**STANDARD HIPAA RESTRICTIONS**

**HIPAA (Health Insurance Portability and Accountability Act of 1966) – A federal law which protects and enhances the right of patients by giving them access to their personal health information and more control over its use.**

**Directions:** If you would like to choose a restriction, **INITIAL** the item on the left side and **SIGN AT THE BOTTOM** of the form. Please be sure you understand what the restriction means before choosing it. **PLEASE DESCRIBE** **YOUR REQUEST AS CAREFULLY AS POSSIBLE IN THE SPACE PROVIDED**. Please realize that if you request other restrictions in subpart below, such restrictions do not begin unless and until approved by the Privacy Officer. Once in place, any restriction will remain in effect until such time that you change it. New restrictions will replace any restrictions that you have made in the past.

1. **Hospital Directory:** If you do not want anyone to receive any information about you including that you are a patient, your location or condition, please initial below that you do not want to be in the directory. If you do not want your general condition and/or religion included in the directory, initial you choice below.

\_\_\_\_\_\_ No Directory. No one will know you are a patient, your room number, condition or religion.

\_\_\_\_\_\_In Directory, do not release general condition.

\_\_\_\_\_\_In Directory, do not release religion.

**\_\_\_\_ b. Individuals Involved in Your Care:** We may disclose information about you to a friend or family member who is involved in your medical care, unless you object. If you object, indicate your choice here.

Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_  **c.** **Appointment Reminders:** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at PPC. We may leave a message for you at any telephone number or email address you give us stating the date, time and location of the appointment. If you want to handle reminders differently, suggest an alternate method here.

 Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ d. **Request for Alternative Type of Communication:** You may request that we communicate with you about medical matters in a certain way or at a certain location. If you want to make this request, indicate your choice here. You must specify how or where you wish to be contacted. We will not ask you the reason for your request. We will accommodate all reasonable requests. We will let you know if we can accommodate your particular request.

 Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_e. **Disaster Relief Purpose:** If a disaster occurs, we will use our professional judgment to decide whether it is in your best interest to disclose information to someone who is involved in your care or to an agency assisting in a disaster relief effort. If you do not want anyone to know this information about you, if you want to limit the amount of information that is disclosed, or if you want to limit who gets this information, indicate you choice here.

 Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ f. **Other Restrictions Requested:**

Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ g. **Restrictions Approved by Privacy Officer:**

Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ h. **Restrictions Not Approved by Privacy Officer:**

Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REMOVAL/CHANGE OF RESTRICTION**

**\_\_\_\_\_ a. Removal (Specify Restriction to be Removed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_ b. Change of Restriction (Specify how Restrictions will be changed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**