

HIPAA Privacy Policy #33
Requested Restrictions on Uses and Disclosures
of Protected Health Information

Effective Date: January 22, 2020	Refer to Privacy Rule Sections: 164.522; 164.530
Authorized by: Equinox Board of Directors	Version #:

Policy: Equinox, Inc. will permit patients to request restrictions on uses and disclosures of Protected Health Information in accordance with the Procedures listed below.

Procedures:

1. **Requests for Restrictions on Uses and Disclosures:** Equinox, Inc. must permit patients to *request* restrictions on how Equinox, Inc. may use and disclose Protected Health Information for treatment, payment and health care operations and how Equinox, Inc. may disclose Protected Health Information pursuant to Equinox, Inc.’s Policy No. 16 entitled “Disclosures of Protected Health Information Without Patient Authorization to Family and Friends.” *45 C.F.R. § 164.522(a)*. See Attachment 1 form entitled “Request for Restriction on Uses and Disclosures of Protected Health Information.”
2. **Certain Requests Must be Granted:** Generally, Equinox, Inc. is not required to agree to a restriction. If, however, the following criteria are met, Equinox, Inc. must grant the request for restrictions: *45 C.F.R. § 164.522(a)(vi)(A) and (B)*.
 - a. **Not Required by Law:** The disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and
 - b. **Paid for by the Patient:** The Protected Health Information pertains solely to a health care item or service for which the patient or person other than the health plan has paid Equinox, Inc. in full.
3. **If Request for Restrictions is Granted:** If Equinox, Inc. does grant a request for restrictions, then Equinox, Inc. must:
 - a. **Document:** Document such restrictions in the patient’s file or record and inform the patient; See Attachment 2 form entitled “Notice of Agreed Upon Restrictions on Uses and Disclosures of Protected Health Information.”
 - b. **Comply:** Comply with such restrictions until the restriction is terminated.
 - c. **Terminate:** Terminate a restriction only if:
 - i. the patient agrees to, or requests, the termination in writing;

- ii. the patient orally agrees to the termination and Equinox, Inc. documents the agreement; or
 - iii. Equinox, Inc. informs the patient that Equinox, Inc. is terminating the restriction without the patient's consent and that the restriction will continue to apply only to information that was created or received prior to the termination. Termination is not effective for Protected Health Information that is restricted because it pertains solely to a health care item or service for which the patient has paid Equinox, Inc. in full. *45 C.F.R. § 164.522(a)(2)*.
- 4. If Request for Restrictions is Denied: If Equinox, Inc. denies a request for restrictions in whole or in part, then Equinox, Inc. must inform the patient of the denial. *See Attachment 3* form entitled "Notice of Denial of Restrictions on Uses and Disclosures of Protected Health Information."
- 5. Requests for Confidential Communications: Equinox, Inc. must permit patients to *request* restrictions on where, when, and how Equinox, Inc. may communicate Protected Health Information to the patients. *See Attachment 4* form entitled "Confidential Communications Request." Equinox, Inc. will employ the following procedures regarding such requests:
 - a. Require Writing: Equinox, Inc. shall require all patients to submit requests for confidential communications in writing. *45 C.F.R. § 164.522(b)(2)(i)*.
 - b. Grant Reasonable Requests: Equinox, Inc. shall grant all reasonable *written* requests for restrictions on where, when and how Equinox, Inc. may communicate Protected Health Information to a patient. *45 C.F.R. § 164.522(b)(1)(i)*.
 - c. Do Not Require an Explanation: Equinox, Inc. may not require an explanation as to the basis of the request for confidential communications. *45 C.F.R. § 164.522(b)(2)(iii)*.
 - d. May Require Alternate Contact Information: Equinox, Inc. may require an patient to provide an alternate address or other method of contact, as a condition of granting a request for confidential communications. *45 C.F.R. § 164.522(b)(1)(i)*.
 - e. May Require Payment Information: Equinox, Inc. may require a patient to provide information about how payment, if any, will be handled, as a condition of granting a request for confidential communications. *45 C.F.R. § 164.522(b)(2)(ii)(A)*.
- 6. If Request for Confidential Communications is Granted: If Equinox, Inc. grants a request for confidential communications restrictions, then Equinox, Inc. must:
 - a. Document: Document such restrictions in the patient's file or record, and inform the patient; *See Attachment 5* form entitled "Notice of Agreed Upon Confidential Communication Request."
 - b. Comply: Comply with such restrictions until the restriction is terminated.
 - c. Terminate: Terminate a restriction only if:
 - i. the patient agrees to, or requests, the termination in writing;

- ii. the patient orally agrees to the termination and Equinox, Inc. documents the agreement; or
 - iii. Equinox, Inc. informs the patient that Equinox, Inc. is terminating the restriction without the patient's consent and that the restriction will continue to apply only to information that was created or received prior to the termination. Termination is not effective for Protected Health Information that is restricted because it pertains solely to a health care item or service for which the patient has paid Equinox, Inc. in full. *45 C.F.R. § 164.522(a)(2)*.
7. If Request for Confidential Communication is Denied: If Equinox, Inc. denies a request for Confidential Communications restrictions in whole or in part, then Equinox, Inc. must inform the patient of the denial. *See Attachment 6* form entitled "Notice of Denial of Confidential Communications Request."
8. Termination of An Agreed Upon Restriction: Equinox, Inc. may terminate an agreement to a Confidential Communications, or use and disclosure restriction, or the patient may seek to have the restriction terminated if:
- a. Patient Request or Consents: The patient agrees to, or seeks, the termination in writing.
 - b. Verbal: The patient verbally agrees and Equinox, Inc. documents the oral agreement; and
 - c. Termination by Equinox, Inc.: Equinox, Inc. informs the patient it is terminating the agreement.

See Attachment 7 form entitled "Termination of Agreed Upon Restriction on Uses and Disclosures of Protected Health Information."

Attachment 1

Request for Restriction on Uses and Disclosures of Protected Health Information

I understand that I have the right to request restrictions as to how my Protected Health Information is used or disclosed for purposes of carrying out treatment, payment or health care operations. Equinox, Inc. is not required to agree to my requested restrictions, but if Equinox, Inc. does agree to such a restriction, the restriction is binding on Equinox, Inc., except as needed to provide me with emergency treatment.

Please indicate your requested restrictions of uses and disclosures of your Protected Health Information.

- I request the following restrictions on the use and/or disclosure of my Protected Health Information for purposes of carrying out treatment, payment or health operations:

- I request the following restrictions on the disclosure of my Protected Health Information (including my location and general condition, or death) to a family member, relative, or close friends directly involved in my care or the payment of my care:

To be completed by _____:

Requested Restriction(s):

- Accepted
- Denied

Attachment 2

**Notice of Agreed Upon Restriction on Uses and
Disclosures of Protected Health Information**

[Date]

[Insert Patient Name]

[Patient Address]

Dear [Insert Patient Name]:

We have approved your requested restriction regarding the use and disclosure of your Protected Health Information as follows:

This restriction may be terminated at any time by either you or us upon written notice to the other.

If you have any questions, please contact us.

_____, Privacy Officer
Equinox, Inc.
500 Central Avenue
Albany, NY 12206
(518) 435-9931

Attachment 3

**Notice of Denial of Restrictions on Uses and
Disclosures of Protected Health Information**

[Date]

[Insert Patient Name]

[Patient Address]

Dear [Insert Patient Name]:

We have not agreed to the restriction that you requested regarding the use and disclosure of your Protected Health Information as set forth below:

Your Protected Health Information will however, receive all the protections available under applicable New York State and Federal law.

If you have any questions, please contact us.

_____, Privacy Officer
Equinox, Inc.
500 Central Avenue
Albany, NY 12206
(518) 435-9931

Attachment 4

Confidential Communications Request

I hereby request that my Protected Health Information, including clinical information (e.g., test results, patient instructions) billing information, and other facility communications (e.g., patient surveys) be communicated to me via the alternate address/phone listed below.

I understand that this request for Confidential Communications will apply to all future communications related to the date of service listed below unless I request a change in writing.

NOTE: This request only applies to communications from Equinox, Inc. If you wish to request Confidential Communications from your physician's office or your insurance company, you must contact them directly.

I understand that if correspondence sent to an alternate address is returned undeliverable, if the alternate phone is disconnected or out of service, or if I fail to respond in a timely manner to communications via an alternate address/phone that I have provided, Equinox, Inc. will communicate with me via other means and/or at other locations.

This request is for the date of service/treatment of: _____

ALTERNATE ADDRESS/PHONE:

NOTE: Only U.S. addresses and phone numbers will be accepted. All information requested below must be completed in order for this request to be processed by the facility.

Patient Name: _____

Street Address: _____

Suite/Apt. Number (if applicable) _____

City: _____

State: _____ Zip Code: _____

Phone Number: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

Attachment 5

Notice of Agreed Upon Confidential Communication Request

[Date]

[Insert Patient Name]

[Patient Address]

Dear [Insert Patient Name]:

We have approved your request for confidential communication of your Protected Health Information as follows:

If you have any questions, please contact us.

_____, Privacy Officer
Equinox, Inc.
500 Central Avenue
Albany, NY 12206
(518) 435-9931

Attachment 6

Notice of Denial of Confidential Communication Request

[Date]

[Insert Patient Name]

[Patient Address]

Dear [Insert Patient Name]:

We have not agreed to your request for confidential communication set forth below:

If one of the following boxes is checked, please submit this information to us for additional consideration.

- Please provide us with information regarding how payment, if any, will be handled.
- Please provide us with an alternative address or other means of contacting you.

If you have any questions, please contact us.

_____, Privacy Officer
Equinox, Inc.
500 Central Avenue
Albany, NY 12206
(518) 435-9931

Attachment 7

**Termination of Agreed Upon Restriction on Uses and
Disclosures of Protected Health Information**

[Date]

[Insert Patient Name]
[Patient Address]

Dear [Insert Patient Name]:

We are terminating our agreement to the following restriction that you requested regarding your request for Confidential Communicaitons or the use and disclosure of your Protected Health Information:

This termination is only effective with respect to Protected Health Information created or received after the date of this notification.

If you have any questions, please contact us.

_____, Privacy Officer
Equinox, Inc.
500 Central Avenue
Albany, NY 12206
(518) 435-9931