HIPAA – FORM A

PEDIATRIC ASSOCIATES

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

PLEASE NOTE: UNDER GOVERNMENT REGULATION WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS. IF WE ARE UNABLE TO APPROVE YOUR REQUEST, WE RESERVE THE RIGHT TO REPLY WITHIN 30 DAYS.

Patient Name: _____ Date of Birth: _____ Account #: _____

Patient Address: _____ City, State, Zip: _____ Phone: _____
Street

I. CHART RESTRICTIONS *(to identify a person/people we should not communicate with)*

Type of Protected Health Information (PHI) to be restricted: (Please check all that apply)

- ☐ Home phone #/Home address
- ☐ Office phone #/ Office address
- ☐ Occupation/Name of employer
- ☐ Spouse name
- ☐ Spouse office phone #
- ☐ Other
- ☐ Patient history
- ☐ Visit notes
- ☐ Hospital notes
- ☐ Prescription Information
- ☐ All Information *(see below)

How would you like your Protected Health Information (PHI) restricted?

_____

_____

* **IMPORTANT:** ***Information will only be restricted from parties not involved in the provision of, payment for, or healthcare operations of your child's care. It will be necessary for us to continue to release information to your insurance company and/or other healthcare providers. If you have any concerns about this, please call our Compliance Officer directly at 954-965-7353.***

_____ _____ _____
Signature of Patient or Legal Guardian | Printed Name of Parent/Guardian | Date

II. CONFIDENTIAL COMMUNICATIONS *(to identify a need for us to communicate with <u>you</u> in a special way).* ***THIS REQUEST CANNOT BE EXECUTED UNLESS COMPLETED***

I, _____, am requesting that Pediatric Associates communicate with me in the alternative manner and/or location described below regarding my/my child's/children's health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996). Such restriction is necessary to prevent a disclosure that could endanger me. I understand that Organization may deny this request if it imposes an unreasonable administrative burden.

<u>Description of the Health Information that Must be Communicated Confidentially</u>. The following is a description of the specific health information to which this request applies:

_____

_____

<u>Alternative Manner and/or Location</u>. ***In order to communicate with you about this visit, we must have a phone number where you can be reached. I request that Pediatric Associates to only communicate with me in the following manner and/or at the location described below. <u>I agree that I can be reached at the following PHONE NUMBER if any communication regarding this visit is required:</u>***

_____

_____

By signing this form, I am confirming that it accurately reflects my wishes

_____ _____ _____
Signature of Patient or Legal Guardian | Printed Name of Parent/Guardian | Date

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III. FUNDRAISING ACTIVITIES – RIGHT TO OPT OUT

I, _____ am requesting that Pediatric Associates or its related entities do not communicate with me or any of my representatives regarding fundraising activities by telephone, regular mail or electronic mail and will not use my name, address, telephone number and dates of service that I received care to gather information for fundraising purposes in accordance with the HIPAA Privacy, Security, Enforcement and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Act (HITECH) and the Genetic Information Nondiscrimination Act published January 25, 2013.

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____ _____

Signature of Patient or Legal Guardian | Printed Name of Parent/Guardian | Date

IV. RESTRICT DISCLOSURE TO HEALTH PLANS FOR TREATMENT PAID OUT OF POCKET IN FULL

I, _____ am requesting that Pediatric Associates not disclose any information to my health insurance carrier for date of service _____ for treatment received in accordance with the HIPAA Privacy, Security, Enforcement and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Act (HITECH) and the Genetic Information Nondiscrimination Act published January 25, 2013. I do not authorize Pediatric Associates to request payment for this visit from my health insurance provider. I understand that I am financially responsible for all charges related to this visit.

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____ _____

Signature of Patient or Legal Guardian | Printed Name of Parent/Guardian | Date

V. RESTRICT DISCLOSURE OF IMMUNIZATION RECORDS TO SCHOOLS

I, _____ am requesting that Pediatric Associates not disclose any of my immunization records to any school in accordance with the HIPAA Privacy, Security, Enforcement and Breach Notification Rules under the Health Information Technology for Economic and Clinical Act (HITECH) and the Genetic Information Nondiscrimination Act published January 25, 2013.

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____ _____

Signature of Patient or Legal Guardian | Printed Name of Parent/Guardian | Date

VI. RESTRICT DISCLOSURE OF PROTECTED HEALTH INFORMATION IN THE EVENT OF DEATH

I, _____ am requesting that Pediatric Associates not disclose any decedent information to family members or others in the event of my death in accordance with the HIPAA Privacy, Security, Enforcement and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Act (HITECH) and the Genetic Information Nondiscrimination Act published January 25, 2013.

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____ _____

Signature of Patient or Legal Guardian | Printed Name of Parent/Guardian | Date

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VII. PROVIDER-PATIENT COMMUNICATIONS – REQUEST TO OPT OUT

I, _____ DO NOT authorize Pediatric Associates to communicate with me via ☐ Home Phone, ☐ Cell Phone / Text, ☐ Work Phone, and / or ☐ by Email to receive communication regarding appointments or other healthcare reminders. (Please select all that apply.)

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____ _____

Signature of Patient or Legal Guardian | Printed Name of Parent/Guardian | Date

VIII. MAINTAIN PAYMENT INFORMATION ON FILE – REQUEST TO OPT OUT

I, _____ DO NOT authorize Pediatric Associates to maintain my payment (debit card and / or credit card) information on file. **OR**

I, _____ authorize Pediatric Associates to maintain my payment (debit card and / or credit card) information on file; but I DO NOT pre-authorize payment for non-covered expenses including ☐ co-payments, ☐ deductibles, ☐ health forms for school, work or athletic teams, and / or ☐ fees for missed appointments. (Please select all that apply.)

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____ _____

Signature of Patient or Legal Guardian | Printed Name of Parent/Guardian | Date

FOR INTERNAL PURPOSES ONLY: Name & Title of Staff Receiving Form _____

Date Staff Received Form: _____ **Date Compliance Officer Received Form:** _____

Approval Status: ☐ **Approved as requested** ☐ **Denied & Notified Date:** _____ **Method:** _____

☐ **Approved with modification:** _____

_____

☐ **Highly Restricted with a Password:** _____

☐ **De-activate access to the Patient Portal** ☐ **EHR Support Notified Date** _____

☐ **Alert Info:** _____

_____

Compliance Officer Initials: _____ **Privacy Admin. Initials:** _____