Great Rivers Behavioral Health
Administrative Services Organization

Policy Title:	**Individual Right to Restrict Uses & Disclosures of Protected Health Information**	Policy No. **5013.00**
Category:	Privacy & Security	Date Adopted: 01/10/2020 Date Revised: Date Reviewed:
Reference:	Washington Health Care Authority; Contract with Great Rivers Behavioral Health Administrative Services Organization; 45 CFR 164.522	

Policy:

1.1. Since the medical records containing PHI are held in the offices of each agency providing services, all requests for restriction of the uses and disclosures will be referred to the Privacy Officer of the appropriate agency.

1.2. The provider will consider a client's request for restriction of the uses and disclosures that the provider makes for purposes of treatment, payment and operations. It will be the provider's policy to discuss with the Client the potential difficulties that are inherent in the restrictions that the Client requests, such as those that might interfere with the Client's ability to obtain appropriate treatment.

1.3. The provider will document the request and, ultimately, the restriction that has been granted to the Client. While the provider is not required by the Privacy Rule to agree to Client-requested restrictions, it will be the provider's policy to grant those restrictions that the provider believes, in their judgment, to be in the best interests of the provider's Individuals of Service.

1.4. The provider will abide by all of the restrictions it grants, except as described below.

1.4.1. When the individual is in need of emergency treatment and the restricted PHI is needed to provide the emergency treatment, the provider's policy will be to make disclosure of the PHI that is required for treatment and to send along with the PHI the requirement that there be no further uses or disclosures of the restricted PHI.

1.4.2. In non-emergency situations, when the provider receives a request for restricted PHI that is required for appropriate treatment, the provider staff will discuss with the Client the need to provide the PHI and attempt to obtain Client's agreement. The Client's agreement, or disagreement, should be documented by completing the bottom of page 3 of the Authorization where Client's agreement or disagreement can be noted in the medical record.

1.5. In any case where the provider believes the Client's restriction can no longer be honored, the provider will terminate the restriction. It will be the provider's policy to discuss the change of circumstance with the Client, ask for his/her agreement and to document the Client's agreement or disagreement in the medical record.

1.6. The restricted PHI that the provider created or received during the term of the restriction will be flagged to assure that future uses and disclosures of it are made in accordance with the restrictions in place for that period.

1.7. Documentation retention requirements include:

1.7.1. Policies and procedures for restrictions to use and disclosure of PHI;

1.7.2. Restrictions granted; and

1.7.3. Terminations

1.8. Other policies and procedures to review that are related to this policy:

1.8.1. Notice of Privacy Practices; and

1.8.2. Administrative requirements – Documentation

Procedure:

2.1. Approval, Notification, and Acting on a Restricted Consent

2.1.1. The right of a Client to ask for a restriction to the Authorization to Use and Disclose Protected Health Information for treatment, payment and health care operations is included in the organization's Notice of Privacy Practices.

2.1.2. The Privacy Officer or designee should advise a Client who asks about requesting a restriction as follows:

2.1.2.1. That the provider does not accept any restriction that would interfere with the provider's direct treatment of the Client, prevent billing, or prevent the provider from complying with the Privacy Rule or other federal or state laws and regulations;

2.1.2.2. The possible or potential consequences, if relevant, to Client's treatment; and

2.1.2.3. The Privacy Officer or designee will respond to a Client's further questions or complaints about Client's requested restrictions to disclosures of PHI.

2.1.3. If the designated behavioral health professional, or designee, agrees with the requested restriction(s) he/she will be responsible for completing with the Client the appropriate documentation to restrictions.

2.1.3.1. The Privacy Officer, or designee, must respond to the request within 2 business days in order to avoid delay or interruption of treatment; and

2.1.3.2. When Client requests and specifically describes restrictions to PHI disclosures to be made under Client's signed Authorization, the Authorization should also be signed by the Privacy Officer, or designee, as approved, where applicable.

2.1.4. The Privacy Officer, or designee, will then be responsible for:

2.1.4.1. Routing the form to medical records for filing the completed and approved Authorization, with the designated restrictions, in the Client's medical record in the appropriate section;

2.1.4.2. Communicating the content of the restriction to appropriate staff;

2.1.4.3. Making sure agency procedures are followed for flagging the Client's medical record to indicate the presence of client-restricted disclosures; and

2.1.4.4. Developing a plan for staff to abide by the restriction while performing Treatment, Payment, and Health Care Operations. The original of this plan and the communication to staff about the restriction will be kept in the medical record in the appropriate section, attached to the Authorization or a request to restrict form. A copy of this same information will be sent to the Privacy Officer for his/her files.

2.1.5. The restriction will not be in effect until the Client has signed the Authorization form requesting restriction(s) or a request to restrict form.

2.1.6. The outside of the medical record will be flagged as follows:

2.1.6.1. Paper records will have a colored sticker applied to the outside of the chart to direct staff to a "Flagged" form kept in the front of Client's chart (directly under the "face sheet") which lists the Restricted Uses and Disclosures; and

2.1.6.2. Electronic records will be flagged by designated staff, either in their entirety or in the restricted fields, to notify anyone accessing the chart that there is restricted disclosure.

2.1.7. The billing and other Client databases as appropriate will be flagged to notify staff of the restriction to the uses and disclosures.

2.1.8. Requests for additional restrictions or modification of the current restriction will follow the steps above.

2.1.9. The Privacy Officer, or designee, accessing or copying a record or database must:

2.1.9.1. Check in every case to see if there is a restriction to uses and disclosures;

2.1.9.2. Thoroughly read the restriction and determine if it applies to the use intended; and

2.1.9.3. Determine and document how best to proceed while complying with the restriction, e.g. removing certain documents before copying, not disclosing certain information at treatment team meetings, and so forth.

2.1.10. If a request for a disclosure, along with an appropriate Authorization form signed by the provider's client or representative, comes from an outside entity asking for information that is restricted, the Privacy Officer should send back the information requested that is not restricted and attach a note or orally inform the requestor that: "Your request for a disclosure has been partially fulfilled because you have requested information that the Client has asked the provider to restrict. Any additional questions should be directed to the Client."

2.2. Terminating a Restriction

2.2.1. Terminating a restriction with the Client's agreement:

2.2.1.1. If the Client agrees to a one-time termination of his/her restriction for a specific disclosure purpose, the disclosure should be documented on the Log of Disclosures form. The documentation should include the Client's signed Authorization, the reason for the one-time termination of his/her restriction, the date, and signature of the clinical person responsible for the disclosure, and the Client's signature, if possible. A copy of the documentation must be sent to the Privacy Officer for his/her records;

2.2.1.2. As treatment progresses the Client may more clearly understand the impact of the restriction on their treatment and may no longer wish to keep the restriction in place;

2.2.1.2.1. This conversation can be initiated by an employee.

2.2.1.2.2. The removal of the restriction should be documented on the original Authorization form or attached to it. The note should include the information that the restriction is being removed for all PHI.

2.2.1.2.3. In an electronic record, the flag should be removed, but the historical information about the restriction must be saved.

2.2.1.2.4. In a paper record the flag on the front of the chart should be removed.

2.2.1.2.5. Any flags in any of the other databases must be removed.

2.2.1.2.6. A copy of the documentation must be sent to the Privacy Officer for his/her records.

2.2.2. Terminating a restriction without the Client's agreement:

2.2.2.1. Restrictions can be terminated by the agency. In these cases, only PHI developed after the date of the restriction will be free of the restriction;

2.2.2.2. Terminating a restriction without the Client's consent should only be done after the Client has been contacted and agreement with the termination has been sought;

2.2.2.3. Terminations without the Client's consent should only happen if the Client's clinician and his/her supervisor believe that:

2.2.2.3.1. The restriction is interfering with the Client's treatment to a degree that service quality is being negatively impacted;

2.2.2.3.2. The restriction compromises the organization's ability to provide medically necessary care; or

2.2.2.3.3. The restriction requires the organization to do something that may violate regulation or law. The primary provider should seek the approval of the Privacy Officer and/or Clinical Manager to terminate the restriction.

2.2.2.4. The Client should be informed either orally or in writing. If orally, the Client's provider should document the oral notice on an attachment stapled to the Authorization form. The documentation should include the reason for termination, approval received from Privacy Officer and/or Clinical Manager, method for notifying Client, and effective date of termination.

2.2.2.5. The flags in the medical record and other databases should note the date of termination of the restriction, but the flag should remain in place for the PHI developed prior to the termination date of the restriction.

2.3. Emergency Situations

2.3.1. When the individual is in need of emergency treatment and the restricted PHI is needed to provide that treatment, disclosure of restricted PHI is allowed:

2.3.1.1. The staff person who will be responsible for the disclosure must make a reasonable attempt to get the Client's agreement to release the restricted information if the Client can consent and treatment will not be interfered with. This should be documented in a progress note; and

2.3.1.2. If the disclosure is oral, the staff person will inform the emergency provider that the PHI disclosed is restricted information and that disclosures must be made in compliance with the restriction going forward. This should be documented in a progress note.

2.3.2. If the restricted information is sent electronically or in writing, notice should be given in writing (or electronically) to the emergency provider that this is restricted information and that disclosures must be made in compliance with the restriction

going forward. A copy of this written notice should be kept in the administrative section of the medical record.

POLICY SIGNATURE

Edna J. Fund DIGITALLY SIGNED

Edna J. Fund, Chair
Great Rivers BH-ASO Governing Board

01/30/2020
08:32 PM EST

Date