Envision HEALTHCARE	Ethics & Compliance Department		
	Policy No.: 25	**Created:**	01/2018
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		Revised:	

HIPAA: RESTRICTION OF USE OR DISCLOSURE

SCOPE:

All Envision Healthcare teammates. For purposes of this policy, all references to "teammate" or "teammates" include temporary, part-time and full-time employees, independent contractors, clinicians, officers and directors.

PURPOSE:

Envision Healthcare Operating, Inc. and its subsidiaries and affiliates ("Envision" or "the Company") has adopted this Restriction of Use or Disclosure policy to define a patient's right to request that a specific use or disclosure of PHI be restricted.

POLICY:

A) The Company will provide patients an opportunity to request a restriction on the use or disclosure of their PHI. The Company does not guarantee that it will agree to restrict the use or disclosure as requested. A restriction must be requested in writing to the Privacy Official (*See* "Request for Restriction on Uses and Disclosures of Health Information" form attached below). Working with the appropriate Office Manager or Director(s), the Privacy Official will take steps to provide or deny the restriction.

B) The Company will always agree to the patient's request to restrict disclosure if the disclosure would be for payment or operations purposes and the PHI at issue only relates to a health care item or service for which the patient (or another individual on behalf of the patient) has made complete payment upfront before services are provided.

C) When feasible, the Company will attempt to honor a patient's request to limit/restrict access to specific elements of his/her medical record.

(1) **Marking the Record**. If the request for restrictions is accepted, mark the relevant portions of the patient's records (including billing and payment records) to protect against improper use or disclosure. Notify any of the business associates who might otherwise use or disclose the information inappropriately.

D) If the Company does agree to a request for restriction, the Company will not use or disclose the PHI unless the patient terminates the restriction, or the use or disclosure of the PHI is required for purpose of providing emergency treatment to the patient. If PHI is disclosed to another provider for emergency treatment, the Company will request that the provider not further disclose the information.

E) A restriction may be terminated by the patient in written or oral form. If the patient terminates the restriction orally, the termination must be documented by appropriate Company staff. The Company may also terminate a restriction and must notify the patient. If the Company initiates the termination of restriction, the termination is only effective with respect to PHI created or received after it has notified the patient.

F) The Company will document any restrictions, denial of restrictions, and terminations of restrictions, and will notify the patient of these actions.

G) Finally, a restriction agreed to by the Company is not effective to prevent uses or disclosures permitted for the following reasons:

(1) When required for any investigation to determine the Company's compliance;

(2) Use and disclosure for facility directories; or

(3) Uses and disclosures for which authorization or the opportunity to agree or object is not required.

POLICY REVIEW

The Ethics & Compliance Department will review and update this Policy, when necessary, in the normal course of its review of the Company's Ethics & Compliance Program.

Envision HEALTHCARE

REQUEST FOR RESTRICTION ON USES AND DISCLOSURES OF HEALTH INFORMATION

1. Name of requesting individual and birth date: _____
2. Date of request: _____
3. Describe the restriction on the Organization's uses and disclosures of your health information that you are requesting and for which *service dates*:

_____

_____

_____

Information on Your Rights to Request a Restriction

You have the right to ask us to restrict how the Organization uses and discloses your health information for purposes of treatment, payment or health care operations (*See* Notice of Privacy Practices for more information on these types of uses and disclosures). You also have the right to ask us to restrict disclosures that we make to those family members or others involved in your care or involved in payment for your care or for notification purposes. We are *not* required to agree to your request. If we do agree, we will put it in writing and will abide by the agreement except when you require emergency treatment. If we do not agree to your request we will notify you of our decision in writing.

By submitting this form, I hereby request the Organization to restrict uses and disclosures of my health information as described above. I understand that the Organization is *not* required to agree to my request.

Name: _____

Signature: _____

Date: _____

Name of Teammate Who Received This Form: _____

Date Form Received: _____

Date Sent to Privacy Official for Approval or Denial of Restriction: _____