Adventist Health

Together inspired™

REQUEST FOR SPECIAL RESTRICTION ON USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Date: _____

Your Name: _____ Date of Birth: _____

I understand that Adventist Health may use or disclose my protected health information ("PHI") for the purposes of treatment, payment and health care operations. AH may also disclose information to someone involved in my care or the payment for my care, such as a family member or friend, under certain circumstances.

I hereby request a special restriction on the hospital's use or disclosure of protected health information.

The information I want limited is:

_____

_____

_____

_____

I want to limit:

☐ The hospital's use of this information.

☐ The hospital's disclosure of this information.

☐ Both the use and the disclosure of this information.

I want the limits to apply to the following person/entity (for example, a spouse):

_____

_____

I understand that AH does not have to agree to my request, unless I am requesting a restriction on disclosure of information to a health plan for payment or health care operations purposes, and I have (or someone on my behalf other than the health plan has) paid for the item or service out of pocket in full. The hospital will still be able to disclose this information to the health plan if required by law.

Even if AH agrees to the restriction, it may share the information anyway in the following circumstances:

- During a medical emergency if the restricted information is needed to provide emergency treatment; however, if the information is disclosed during an emergency, Adventist Health - Castle will tell the recipient not to use or disclose it for any other purposes.
- Inclusion in the hospital's directory.
- For certain public health activities.
- For reporting abuse, neglect, domestic violence or other crimes.
- For health agency oversight activities or law enforcement investigations.
- For judicial or administrative proceedings.
- For identifying decedents to coroners, medical examiners and funeral directors or determining a cause of death.
- For organ procurement.
- For certain research activities.
- For workers' compensation programs.
- To avert a serious threat to health or safety.
- To the Secretary of Health and Human Services.
- For specialized government functions.
- For uses or disclosures otherwise required by law.

If a special restriction is agreed to, it may be terminated if:

1. I request, or agree to, the termination in writing; or
2. I orally agree to the termination and the oral agreement is documented; or
3. The hospital informs me that it is terminating the agreement. In this case, the termination is only effective for PHI created by the hospital or received by the hospital after I am notified of the termination. The hospital cannot terminate a special restriction on disclosure to a health plan for payment or health care operations purposes for items or services paid out of pocket in full, unless I agree.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient / legal representative)

If signed by someone other than patient, indicate relationship:

Print Name: _____
(legal representative)

For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website at www.adventisthealth.org or by sending a written request to the Privacy Office.

If you believe your privacy rights have been violated, you may file a complaint with Adventist Health or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with AH, you many call the Privacy Office at 1-808-263-5421. *You will not be penalized for filing a complaint.*

INTERNAL USE ONLY

Privacy Official or Designee's Approval of Restriction Required

Response to Request: ☐ Approved ☐ Denied

Reason for denial, if request denied:

_____

_____

_____

Signature: _____ Date: _____

(Privacy Official or designee)

TERMINATION OF RESTRICTION

☐ Individual requests orally or in writing to terminate restriction

☐ Facility informed the individual of termination of the agreed-upon restriction**

Reason for termination:

_____

_____

_____

Signature: _____ Date: _____ Time: _____

(Privacy Official or designee)

** *Termination is only effective with respect to PHI created or received* ***after*** *the individual has been notified of the termination.*