


<b>Name of Policy:</b> Patient request for confidential communications  <b>Policy Number:</b> 3364-90-18  <b>Approving Officer:</b> President  <b>Responsible Agent:</b> Privacy Officer and Director of Health Information Management  <b>Scope:</b> Hybrid and affiliated covered entity of University of Toledo		  <b>Effective date:</b> September 13, 2023  <b>Original effective date:</b> November 15, 2010	
<b>Keywords:</b>			
	New policy		Minor/technical revision of existing policy
	Major revision of existing policy	X	Reaffirmation of existing policy

(A) Policy Statement

The hybrid and affiliated covered entity are committed to ensuring the safety and well-being of its patients and the protection of their health information. In accordance with federal regulations (45 C.F.R. Section 164.522), reasonable requests for confidential communications to be made to alternative locations or through alternative means will be accommodated.

(B) Purpose of Policy

The purpose of this policy is to provide guidance with respect to the documentation and processing of requests to receive confidential communications.

(C) Procedure

(1) Individual rights

- (a) Individuals have a right to request that communications regarding protected health information (PHI) be provided through a specific means.
- (b) Individuals have a right to request that communications regarding PHI be provided at alternative locations.
- (c) Individuals have a right to decline to provide an explanation for the basis for a request for confidential communications.

(2) Institutional rules and obligations

- (a) UTMC and its healthcare components will permit an individual to request confidential communication by an alternative means or at an alternative location.
- (b) The individual may make the request without having to change their primary contact information on file and for a specified period of time if applicable.
- (c) UTMC or its healthcare components may not require an explanation from the individual for the basis of the request as a condition of granting the request.
- (d) UTMC or its healthcare components, in appropriate circumstances, may condition the grant of a request for confidential communication upon a satisfactory payment arrangement to cover the cost of the communication.

(3) Documentation

- (a) Individuals complete/or review the “request for confidential communication” form annually. Patient may make changes by submitting a new “request for confidential communication” form to HIM.
- (b) HIM will evaluate the request and may grant the request if reasonable.
- (c) Where the means or locations contained in the request involve incurring costs over and above the usual costs of such communications, the request may be granted if a payment arrangement is agreed upon with the individual.
- (d) A request for confidential communications which is not made in person may be granted subject to the verification of the identity of the individual making the request in addition to other previously addressed conditions.
- (e) A request must be documented if given orally by completing a “request for confidential communication” form on behalf of the individual, in addition to other documentation sufficient to support a finding that an oral request was made. If this is an emergent situation where a patient cannot be physically present to make the request, documentation from the requestor will be required, such as power of attorney for healthcare.
- (f) If the form is filled out on behalf of the individual, the individual must be made aware of his/her responsibilities with respect to payment (if applicable), accuracy of information provided and notice to UTMC should any of the information provided change.

(D) Definitions

- (1) Covered component(s) or designated health care component – the university of Toledo medical center, the UT medical staff, UT clinics (including the university of Toledo student and employee health clinics), the entire health science campus and

other covered components as designated by the privacy officer (legal, audit, compliance) and the university of Toledo physicians, LLC.

- (2) Protected health information (PHI) – Health information that identifies or can be used to identify an individual and is considered PHI under HIPAA. Any of the following information pertaining to a patient or the relatives, employees or household members of the patient, can be used to identify a patient and include: name, street address, city, county, precinct, zip code, geocode, birth date, admission date, discharge date, date of death, age, telephone number, fax number, e-mail, social security number, medical records number, health plan number, account number, certificate/license number, vehicle ID number or license plate, device identifier, web location, internet address, biometric identifier, photographs or any unique ID.

PHI does not include:

- (a) Individually identifiable health information in education records covered by FERPA.
- (b) Records on a student of the university which are made or maintained by a physician, psychiatrist, psychologist, or other recognized professional or paraprofessional acting in that person's professional or paraprofessional capacity, or assisting in that capacity, and which are made, maintained, or used only in connection with the provision of treatment to the student, and are not available to anyone other than persons providing such treatment, except that such records can be personally reviewed by a physician or other appropriate professional of the student's choice.
- (c) Employment records held by the university in its role as employer.
- (d) Individually identifiable health information for people who have been deceased for more than fifty years.
- (3) Individual is a person who is the subject of the PHI or with respect to use and disclosure of PHI an authorized personal representative of the person (invoked health care power of attorney, guardian or executor) shall be treated as the individual.
- (a) A healthcare provider may elect not to treat a person as a personal representative if:
- (i) The healthcare provider believes that an individual has been or may be subjected to domestic violence, abuse or neglect by such person, or that treating such person as the personal representative could endanger the individual; and
- (ii) The healthcare provider decides that it is not in the best interest of the individual to treat such person as the individual's personal representative.

<p><b>Approved by:</b></p> <p><i>/s/</i></p> <hr/> <p>Gregory Postel, MD President</p> <p><b>Date:</b> September 13, 2023</p> <p><b>Review/revision completed by:</b></p> <ul style="list-style-type: none"><li>• <i>Privacy and Security Committee</i></li><li>• <i>Senior Leadership Team</i></li></ul>	<p><b>Policies superseded by this policy:</b></p> <ul style="list-style-type: none"><li>• <i>None</i></li></ul> <p><b>Original effective date:</b> <i>November 15, 2010</i></p> <p><b>Review/revision date:</b> <i>September 1, 2013</i> <i>September 1, 2016</i> <i>October 6, 2020</i> <i>September 13, 2023</i></p> <p><b>Next review date:</b> <i>September 13, 2026</i></p>
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Request for Confidential Communication of Protected Health Information.
Privacy Office
3065 Arlington Avenue Mulford Library 224
Toledo, Ohio 43614 419 383-4994

Patient Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

MRN: \_\_\_\_\_

I request that my protected health information be disclosed via

[ ] E-mail (Specify e-mail address) \_\_\_\_\_

[ ] Telephone (Specify phone number) \_\_\_\_\_

[ ] Leave voicemail if no answer

[ ] Do not leave voicemail if no answer

[ ] Regular mail (Specify address) \_\_\_\_\_

[ ] Instant Messaging (Specify address) \_\_\_\_\_

[ ] Express mail/Courier (Specify address- charges may apply)

I request to have my protected health information disclosed by the method selected above from:

[ ] Until further notice

[ ] From \_\_\_\_\_ to \_\_\_\_\_ (dd/mm/yyyy)

I understand that UTMC is not required to grant my request and in some cases my request will only be granted if I agree to pay for the cost of the communication. I affirm that the contact information provided is accurate to the best of my knowledge. I understand that it is my responsibility to notify the UTMC of any changes to my contact information or if I no longer wish to be contacted via the method requested on this form.

Signature of Patient/Legal Representative (relationship) \_\_\_\_\_

\_\_\_\_\_ Date

Please indicate below if you would like to receive a copy of our "Notice of Privacy Practices"

(Also available online at: utmc.utoledo.edu/patient\_guests/services/privacy.html)

[ ] Yes [ ] No

For UTMC office use only

UTMC Response to Request

Date of Receipt of Request \_\_\_\_\_

Response to request

[ ] granted [ ] denied.

Payment required:

[ ] Yes [ ] No

Signature of Reviewing Officer \_\_\_\_\_

\_\_\_\_\_ Date