**COUNTYOF LOS A NGELES DEPARTMENT OF HEALTH SERVICES**

**HARBOR-UCLA MEDICAL CENTER**

**SUBJECT: RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS OF PROTECTED HEALTH INFORMATION (PHI) POLICY NO. 708**

**PURPOSE:**
To establish a policy and procedure pursuant to the HIPAA Privacy Rule to ensure that patients can receive communications regarding their Protected Health Information through an alternative means or at an alternative location in order to preserve the confidentiality of the communications.

**POLICY:**
Harbor-UCLA Medical Center will provide individuals with an opportunity to request to receive Protected Health Information in a Confidential Communication. Harbor-UCLA Medical Center will accommodate reasonable requests by patients to receive Confidential Communications of Protected Health Information.

**DEFINITIONS:**
"Confidential Communications" means a communication between an individual and Harbor-UCLA Medical Center that includes Protected Health Information and is sent through alternative means or to an alternative location from the regular or routine method of communication.

**PROCEDURES:**
I. Harbor-UCLA Medical Center requires patients to request Confidential Communications in writing by completing and submitting the ***Patient's Request for Confidential Communications*** form (Attachment A).
II. Harbor-UCLA Medical Center will not require an explanation from the patient concerning the basis for the request as a condition of providing Confidential Communications.
III. Harbor-UCLA Medical Center may condition the granting of a request for Confidential Communications based on the following:
   A. In appropriate situations, Harbor-UCLA Medical Center may require the individual to provide information as to how payment, if any, will be handled;
   B. Harbor-UCLA Medical Center may require the individual to specify an alternative address or an alternative method of contacting the individual.

**EFFECTIVE DATE: 04/14/03** **SUPERSEDES**
**REVISED:**
**REVIEWED: 12/08, 05/14, 07/17**
**REVIEWED COMMITTEE:**

**APPROVED BY:**

| | |
|---|---|
| **Kim McKenzie, RN, MSN, CPHQ** | **Anish Mahajan, MD** |
| **Chief Executive Officer** | **Chief Medical Officer** |

**Patricia Soltero Sanchez, RN, BSN, MAOM**
**Chief Nursing Officer**

Signature(s) on File.

IV. Harbor-UCLA Medical Center is responsible for determining, on a case-by-case basis, whether an individual's request for a Confidential Communication is reasonable.

V. If the ***Patient's Request for Confidential Communications*** is approved, Harbor-UCLA Medical Center shall, whenever communicating with the individual in a way that includes the individual's Protected Health Information, communicate in the manner and/or the location specified in the Request Form. Harbor-UCLA Medical Center shall ensure that all appropriate Workforce Members are notified of the alternative means of communicating the information and are in compliance with the Confidential Communications request.

VI. The ***Patient's Request for Confidential Communications*** form will be filed in the patient's medical record and retained in accordance with Harbor-UCLA Medical Center's Policy #618, "Retention of Medical Records and X-ray Films", At the patient's request, Harbor-UCLA Medical Center will give the patient a copy of the signed request form.

VII. If the request is denied, the Harbor-UCLA Medical Center Privacy Coordinator will document such decision by completing a ***Letter of Denial Regarding Patient's Request For Confidential Communications*** (Attachment B), which sets forth the basis for Harbor-UCLA Medical Center' decision to deny the request. A copy of the letter will be included in the patient's medical record for future reference.

VIII. Harbor-UCLA Medical Center will document compliance and maintain the policy/procedure by retaining copies of the policy/procedure, and its associated forms, for a period of at least 6 years from the date of its creation or the date when it last was in effect, whichever is later.

**REFERENCE:**
45 Code of Federal Regulations § 164.512 (a).
DHS Medical Records Retention Policy #881.

ATTACHMENT A

DHS

## PATIENT'S REQUEST FOR CONFIDENTIAL COMMUNICATIONS

***Note: This form applies only to requests for confidential communications, i.e., when an individual is requesting a special manner of communication based on confidentiality concerns. This form is NOT to be used merely to notify the Department of Health Services (DHS) of a change in address or other contact information.***

Please type or print the patient's information:

Last Name First MI Date of Birth (mo/d/yr) Medical Record #

Street Address City State Zip Code

You have the right to request to receive confidential communications of health information by alternative means or at alternative addresses. For example, if you do not want your appointment notices or your bills to go to your home where a family member might see them, you may ask us to communicate with you by another method or at an alternative location, such as a post office box.

We will not ask you the reason for your request. We will accommodate all reasonable requests to receive communications from us by alternative means or at alternative locations.

If you ask us to communicate with you in a different manner or at a different location than we are now using, you must give us an alternative address or other method of contacting you (phone number, email address, etc.). Please specify how or where you wish to be contacted:

Alternate Address (postal or email):

_____

_____

_____

New Phone Number (include area code): _____

Indicate what method of communication NOT to use: _____

Signature of patient or representative: _____

If representative, give relationship: _____

**APPROVAL**

Signature of Treatment Provider: _____ Date: _____

**ATTACHMENT B**

*USE OFFICIAL COUNTY LETTERHEAD FOR OUTSIDE CORRESPONDENCE*

## LETTER OF DENIAL REGARDING PATIENT'S REQUEST FOR CONFIDENTIAL COMMUNICATIONS

{Date}

{Patient's name}
{Address}

Medical Record #: _____

Date of Birth: _____

Dear {Mr./Ms.)

Thank you for submitting your ***Patient's Request For Confidential Communications*** form. DHS has reviewed your request to receive communications involving your health information from us through an alternative means or to an alternative location and has determined that it must deny your request.

Reason for denial: {insert}

If you have any questions, please contact the {Name of Facility) or call us at *[phone number]*.

Thank you for providing us with this opportunity to serve you and improve the accuracy and completeness of your health information. We look forward to continuing to serve your health care needs.

Sincerely,

{Facility Official
{Address}