

PURDUE UNIVERSITY
REQUEST OF PRIVACY PROTECTION OF PROTECTED HEALTH INFORMATION

Patient or Employee's Name: _____ Date of Birth: _____

Patient or Employee's Address: _____

Patient or Employee's I.D.#: _____ Phone #: _____

I hereby request that the employees of Purdue University honor the following restrictions regarding the use and disclosure of the protected health information of the individual indicated above.

HIPAA Covered areas to which the restriction applies: _____

Or All HIPAA covered areas at Purdue

Please indicate the type of disclosure to be restricted and describe the specific restriction and protected health information to which it pertains:

Use or disclosure relating to treatment, payment and/or healthcare operations (refer to definitions on page 2).

Use and disclosure of protected health information to a family member, other relative, or other identified person, directly relevant to this person's involvement with the individual's care or payment for health care.

Use and disclosure of protected health information relating to the individual's location, general condition or death to a family member, a personal representative or other person responsible for the care of the individual.

Use and disclosure relating to a person acting on the behalf of the individual to pick up filled prescriptions, medical supplies, X-rays or other similar forms of protected health information.

Use and disclosure to a public or private entity authorized by law or its charter to assist in disaster relief efforts.

I understand that Purdue University is not required to agree to the restriction requested above, and the restriction will not be effective unless the Director of HIPAA Privacy Compliance accepts it in writing below. If the Director, HIPAA Privacy Compliance agrees to the stated restriction, Purdue may not use or disclose the protected health information in violation of the restriction, except, if the individual who requested the restriction is in need of emergency treatment and the restricted information is needed to provide the emergency treatment, Purdue may use the restricted information or may disclose the information to a health care provider to provide treatment to the individual and must request that the health care provider not further use or disclose the information. Any restriction agreed to by Purdue is not effective to prevent uses or disclosures permitted or required in the HIPAA Privacy Rule, §§ 164.502(a)(2)(ii), (disclosures to the Secretary of HHS); 164.510(a), (facility directory information); or 164.512, (e.g., disclosures required by law, public health disclosures, research, etc.).

I further understand, that I may revoke this restriction orally or in writing at any time by mailing or delivering a written revocation to: Director, HIPAA Privacy Compliance, Purdue University Health Center, Room B54, 601 Stadium Mall Drive, West Lafayette, IN 47907-2052, Phone: (765) 496-1927, FAX: (765) 496-1227, email: hipaa-privacy@purdue.edu

The revocation will be effective 2 business days after receipt by the Director, HIPAA Privacy Compliance.

A copy of this form will be mailed to the address of the individual or his or her personal representative after review. Any restriction will be effective on the date indicated below after approval of the Director, HIPAA Privacy Compliance. If Purdue agrees to any restriction, I understand that Purdue may terminate the restriction by giving me written or oral notice of the termination. The termination will be effective with respect to any protected health information created or received after the termination date indicated by Purdue.

Signed _____ Date _____
Name of Individual or Personal Representative

Printed Name Individual or Personal Representative Relationship to Individual (if not patient/employee)

Address (if other than patient's address)

Restriction Accepted: _____ Date _____
Director, HIPAA Privacy Compliance

Restriction NOT Accepted: _____ Date _____
Director, HIPAA Privacy Compliance
Date Restriction Begins _____

Printed Name

Reason NOT Accepted:

Mail or FAX this form to: Director, HIPAA Privacy Compliance, Purdue University Health Center, Room B54, 601 Stadium Mall Drive, West Lafayette, IN 47907-2052, Phone: (765) 496-1927, FAX: (765) 496-1227

USE AND DISCLOSE OF YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

For treatment. The Health Care Providers may use and disclose your health information to provide or assist with your treatment. For example, we may provide your health information to a laboratory in order to obtain a test result important for diagnosing or treating a condition you may have.

To obtain payment for health care services. We may use and disclose your health information in order to bill and collect payment for the treatment and services provided to you. For example, we may provide limited portions of your health information to your health plan to get paid for the health care services we provide to you. We may also provide your health information to our business associates who assist us with billing, such as billing companies, claims processing companies, and others that process our health care claims. We will only disclose the minimum amount of information needed to obtain payment.

For health care operations. Your health information may also be used or disclosed to improve and conduct health care operations. For example, we may use your health information in order to evaluate the quality of health care services that you received, or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your health information to our auditors, attorneys, consultants, and others in order to make sure we are complying with the laws that affect us. We may also use a sign-in sheet at registration or other appropriate areas, and we may call you by name in waiting and service areas.