Pediatric Partners of Virginia
HIPAA Form A
Request for Limitations and Restrictions of Protected Health Information

PLEASE NOTE: *UNDER GOVERNMENT REGULATION WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS. IF WE ARE UNABLE TO APPROVE YOUR REQUEST, WE RESERVE THE RIGHT TO REPLY WITHIN 30 DAYS.*

Patient Name: _____ Date of Birth: _____ Account #: _____

Patient Street Address: _____ City, State, Zip: _____ Phone: _____

I. CHART RESTRICTIONS *(to identify a person/people we should not communicate with)*
Type of Protected Health Information (PHI) to be restricted: (Please check all that apply)

□ Home phone #/Home Address
□ Work phone#/Employer
□ Patient History
□ Visit Notes
□ Hospital Notes
□ Prescription Information
□ All Information
□ Other _____

How would you like your Protected Health Information (PHI) restricted? _____
_____

*** IMPORTANT:** ***Information will only be restricted from parties not involved in the provision of, payment for, or healthcare operations of your child's care. It will be necessary for us to continue to release information to your insurance company and/or other healthcare providers. If you have any concerns about this, please call our Corporate Administrator at (804) 464-2018.***

_____ _____ _____
Signature of Parent/Guardian | Printed Name | Date

II. CONFIDENTIAL COMMUNICATIONS (to identify a need for us to communicate with you in a special way).
THIS REQUEST CAN NOT BE EXECUTED UNLESS COMPLETED

I, _____, am requesting that Pediatric Partners of Virginia communicate with me in an alternative manner and/or location described below regarding my/my child's/children's health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act). Such restriction is necessary to prevent a disclosure that could endanger me. I understand that the Organization may deny this request if it imposes an unreasonable administrative burden.

Description of the Health Information that Must be Communicated Confidentially. The following is a description of the specific health information to which this request applies: _____
_____

Alternative Manner and/or Location. In order to communicate with you about this visit, we must have a phone number where you can be reached. I request that Pediatric Partners of Virginia to only communicate with me in the following manner and/or at the location described below. *I agree that I can be reached at the following PHONE NUMBER if any communication regarding this visit is required:* _____

By signing this form, I am confirming that it accurately reflects my wishes:

_____ _____ _____
Signature of Parent/Guardian | Printed Name | Date

III. FUNDRAISING ACTIVITIES – RIGHT TO OPT-OUT

I, _____ am requesting that Pediatric Partners of Virginia or its related entities do not communicate with me or any of my representatives regarding fundraising activities by telephone, regular mail or electronic mail and will not use my name, address, telephone number and dates of service that I received care to gather information for fundraising purposes in accordance with the HIPAA Privacy, Security, Enforcement and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Act (HITECH) and the Genetic Information Nondiscrimination Act.

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____ _____

Signature of Parent/Guardian | Printed Name | Date

IV. RESTRICT DISCLOSURE TO HEALTH PLANS FOR TREATMENT PAID OUT OF POCKET IN FULL

I, _____ am requesting that Pediatric Partners of Virginia not disclose any information to my health insurance carrier for date of service _____ for treatment received in accordance with the HIPAA Privacy, Security, Enforcement and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Act (HITECH) and the Genetic Information Nondiscrimination Act. I do not authorize Pediatric Partners of Virginia to request payment for this visit from my health insurance provider. I understand that I am financially responsible for all charges related to this visit.

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____ _____

Signature of Parent/Guardian | Printed Name | Date

V. RESTRICT DISCLOSURE OF IMMUNIZATION RECORDS TO SCHOOLS

I, _____ am requesting that Pediatric Partners of Virginia not disclose any of my immunization records to any school in accordance with the HIPAA Privacy, Security, Enforcement and Breach Notification Rules under the Health Information Technology for Economic and Clinical Act (HITECH) and the Genetic Information Nondiscrimination Act.

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____ _____

Signature of Parent/Guardian | Printed Name | Date

VI. RESTRICT DISCLOSURE OF PROTECTED HEALTH INFORMATION IN THE EVENT OF DEATH

I, _____ am requesting that Pediatric Partners of Virginia not disclose any decedent information to family members or others in the event of my death in accordance with the HIPAA Privacy, Security, Enforcement and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Act (HITECH) and the Genetic Information Nondiscrimination Act.

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____ _____

Signature of Parent/Guardian | Printed Name | Date

VII. PROVIDER-PATIENT COMMUNICATIONS – REQUEST TO OPT-OUT

I, _____ DO NOT authorize Pediatric Partners of Virginia to communicate with me via ☐ Home Phone, ☐ Cell Phone / Text, ☐ Work Phone, and/or ☐ by Email to receive communication regarding appointments or other healthcare reminders. (Please select all that apply.)

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____ _____

Signature of Parent/Guardian | Printed Name | Date

VIII. MAINTAIN PAYMENT INFORMATION ON FILE – REQUEST TO OPT-OUT

I, _____ DO NOT authorize Pediatric Partners of Virginia to maintain my payment (debit card and/or credit card) information on file. **OR**

I, _____ authorize Pediatric Partners of Virginia to maintain my payment (debit card and/or credit card) information on file; but I DO NOT pre-authorize payment for non-covered expenses including ☐ co-payments, ☐ deductibles, ☐ health forms for school, work or athletic teams, and/or ☐ fees for missed appointments. (Please select all that apply.)

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____ _____

Signature of Parent/Guardian | Printed Name | Date

FOR INTERNAL PURPOSES ONLY

Name & Title of Staff Receiving Form: _____ _____
Date Staff Received Form: _____ *Date Compliance Officer Received Form:* _____

Approval Status:

□ *Approved as requested*
□ *Denied & Notified Date:* _____ *Method:* _____
□ *Approved with modification:* _____
_____
□ *Highly Restricted with a Password:* _____
□ *De-activate access to the Patient Portal* □ *EHR Support Notified Date* _____
□ *Alert Info:* _____
_____

Compliance Officer Initials: _____ *Privacy Admin. Initials:* _____