KINGS VIEW

SPECIAL RESTRICTION ON USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I. REQUEST

Date: ______________________________ Medical Record #: ____________________

Client Name: ______________________________ Date of Birth: ____________________

I understand Kings View may use or disclose my protected health information for the purposes of treatment, payment and health care operations. I request a special restriction on Kings View' use or disclosure of my protected health information. The information I want limited is:

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I want to limit Kings View's:

______ **Uses** of this information.

______ **Disclosure**s of this information.

______ **Both the use and the disclosure** of this information.

I want the limits to apply to the following person/entity:

____

I understand Kings View 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. Kings View will still be able to disclose this information to the health plan if required by law.

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

- In a medical emergency if the restricted information is needed to provide emergency treatment. However, if the information is disclosed in an emergency, Kings View will tell the recipient not to use or disclose it for any other purposes.
- 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 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.

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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 verbally agree to the termination and the oral agreement is documented; or
3. Kings View informs me it is terminating the agreement. In this case, the termination is only effective for PHI created or received by Kings View after I am notified of the termination. Kings View 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: ____
(Client/legal representative)

If signed by someone other than client, indicate relationship: ______________________

Print name: ____
(Legal representative)

RETURN this form to the Kings View facility where you receive (d) services.

For more information about your privacy rights-

- See the *Notice of Privacy Practices* available on our website at www.kingsview.org OR
- Obtain a copy of the *Notice of Privacy Practices* at the facility where you receive(d) services.

If you believe your privacy rights have been violated, you may file a complaint. *You will not be penalized for filing a complaint.*

To file a complaint with Kings View, call or write the Privacy Officer. All complaints must be submitted in writing to:

Kings View
Attention: Privacy Officer
7170 N. Financial Drive, Suite 110
Fresno, CA 93720
Phone (559) 256-1080

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services
Office of Civil Rights
90 7th Street, Suite 4 – 100
San Francisco, CA 94103
Phone (800) 368-1019
TDD (800) 537-7697

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II. RESPONSE

_____ Request APPROVED _____ Request DENIED

_____ Other

By: ______________________________ ______________________________

Print Name *Title*

______________________________ ______________________________

Signature *Date*

III. CLIENT NOTIFICATION

Date Notified: ____________________ Method: ______ Mail ____ Telephone _____ In Person

By: ______________________________ ______________________________

Print Name *Title*

______________________________ ______________________________

Signature *Date*