FAMILY COUNSELING ASSOCIATES OF ANDOVER, LLC

12 Essex Street | Andover, MA 01810

Request for Restriction on Use or Disclosure of Protected Health Information

The privacy of your Protected Health Information is protected by HIPAA and state mental health confidentiality rules. However, Family Counseling Associates of Andover, LLC (FCA) is permitted by HIPAA to use and disclose your protected health information, with certain limits and protections, for treatment, payment and health care operations activities. Pursuant to HIPAA, you have the right to request restrictions on FCA's use and disclosure of your protected health information for treatment, payment or health care operations activities. FCA is not required to agree to your request for restrictions, but if FCA does agree to your request, it is bound by that agreement and cannot use or disclose your protected health information in a manner inconsistent with an agreed-upon restriction.

Patient's Name:____ Patient's Birth Date:______________________

I request that FCA restrict the use and disclosure of my protected health information ("PHI") for purposes of treatment, payment or healthcare operations as follows:

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1. I understand that FCA is not required by HIPAA to agree to this restriction, unless the restriction concerns a disclosure to a health plan for purposes of carrying out payment or health care operations and such disclosure is not otherwise required by law and the restriction concerns PHI which pertains solely to a health care item or service for which FCA has been paid out of pocket by me in full.

2. If FCA agrees to this restriction, I understand the restriction may be terminated at any time if permitted by APA ethical and state confidentiality rules. A termination of this restriction is effective for PHI that FCA creates or receives after the date it informs me of such termination. Restrictions concerning a disclosure to a health plan for purposes of carrying out payment or health care operations where such disclosure is not otherwise required by law and concerns PHI which pertains solely to a health care item or service for which FCA has been paid out of pocket by me in full will not be terminated unless I request such termination in writing.

3. Even if the request is granted, I understand that restricted PHI may be used or disclosed to provide emergency treatment for me or as otherwise required by law. However, the emergency treatment provider will be asked not to redisclose any restricted PHI.

4. I understand that in accordance with other applicable law, the types of uses and disclosures I have written above may or may not be otherwise permitted.

5. I also understand that my right to request restrictions under this HIPAA provision only extends to use or disclosure for treatment, payment or health care operations. My right to authorize the use and disclosure of protected health information for other purposes (or to withhold consent) is addressed in separate policies and the HIPAA Notice of Privacy Practices.

6. I will be notified in writing of the action taken on this request. If a request is not specifically listed above and agreed to in writing, it will not be effective.

____ ____________________

Signature of Patient or Representative/Guardian Date

____ ____________________

Signature of Staff Member Date

For Organization Use Only: Date Request Received: _____________ Date of Written Response: _____________

Action taken: Granted Denied (if denied, state reason below):