SUNY RF
The Research Foundation for
The State University of New York

Request for Special Handling of Protected Health Information (PHI)

This form should be used by an employee or dependent covered by a Research Foundation health plan (Plan) who wishes to invoke special rights with respect to his/her Protected Health Information (PHI) under the HIPAA privacy rules. "Protected Health Information" means health information that identifies me or can be used to ascertain my identity and which is maintained by the Plan and/or transferred to another entity in either written or electronic form.

In order to exercise your rights, the relevant section(s) should be completed, and then the form should be submitted to the health Plan representative at the employee's operating location. For dependents under the age of 18, or for whom the employee has been appointed legal guardian, this form should be completed by the employee.

For more information about patient rights, refer to the Foundation's Notice of Privacy Practices.

Right to restrict use and disclosure of PHI

I understand that the Plan may use or disclose my PHI for treatment, payment, or health care operations purposes (TPO Purposes) or for other purposes related to my care, including communication with a family member or close friend for treatment, payment, and notification purposes, including identification and location purposes, or for disaster relief purposes (Special Purposes). I also understand that I have the right to request that the Plan NOT disclose certain of my PHI (Restricted Information"). I understand that, except as described below, the Plan's decision with regard to this Request is completely discretionary and that the Plan IS NOT REQUIRED to agree to any Request. I understand that the Plan may not deny a Request to restrict disclosure of PHI to another health plan for payment or health care operations purposes where the PHI relates solely to a health care item or service for which a health care provider has been paid out-of-pocket and in full, unless the disclosure is otherwise required by law. I understand that if the Plan agrees to the Request (Agreement), then the Plan will not be permitted to use or disclose the Restricted Information in violation of the Agreement. I understand that even if the Plan agrees to the Request, there may be circumstances in which the Plan will be permitted or required by law to use or disclose the Restricted Information, including, but not limited to, for my own emergency treatment, for law enforcement purposes, public health activities, health oversight activities and certain other purposes.

____ I hereby request that the Plan NOT use or disclose the following Restricted Information for TPO Purposes or Special Purposes (please be specific):

_____ I hereby request that the Plan NOT use or disclose the following Restricted Information to another health plan for payment or health care operations purposes because the Restricted Information pertains solely to a health care item or service for which a health care provider has been paid out of pocket and in full.

NOTE: The Plan will continue to use or disclose your PHI until the Plan makes a determination of whether to agree or not agree to the Request. You will be notified via regular mail of such determination.

I understand that if the plan agrees to this restriction, either the plan or I may terminate this restriction at any time. I understand that if restricted PHI must be used or disclosed to provide emergency treatment for me, or to comply with legal requirements, then this restriction is void.

Right to account for disclosures of PHI

_____ By checking here, I request an accounting of how my PHI has been disclosed by the following health, dental, or vision plan: _____

The accounting should cover the following period: _____

I understand that the plan is not required to provide an accounting of disclosures made for reasons that are permitted under HIPAA, or prior to the compliance date of April 14, 2003.

Right to access PHI for inspection and/or copying

I request access to the following PHI about me that is held by or on behalf of the following health, dental, or vision plan (please be specific):

_____

I understand that the Plan generally honors Requests for Access, but that there are certain circumstances in which the law allows the Plan to deny Requests for Access.

_____ I want to inspect the PHI at the Foundation offices.

_____ I want to obtain a copy of the PHI, and agree to pay reasonable copying fees.

_____ I request that a copy of PHI be mailed to the following address, and agree to pay postage:

I understand that if my Request for Access is granted or partially granted, the Plan will notify me so that I can make an appointment for a time to inspect my records. I understand that if I request copies, the Plan will make the copies and will charge me a reasonable fee for the cost of the copies. I understand that under no circumstances will I be allowed to remove my records or any of the contents of my records from the premises.

If my Request for Access is denied or partially denied, I will be notified in writing of the Plan's decision and the reasons for the denial. I understand that the Plan has a review process, and that depending on the grounds for the Plan's denial of my Request for Access, I may be entitled to a review of the Plan's decision. I understand that the notice from the Plan will give me more information about this option if it applies to me.

SUNY RF
The Research Foundation for
The State University of New York

Right to amend or supplement PHI

I want to amend or supplement my PHI that is held on or behalf of the following health, dental, or vision plan as follows (please be specific as possible and attach any relevant documents):

The reason for amending or supplementing the PHI is:

I understand that if the PHI was not created by the Plan, the Plan is not required to honor my request and may instead require that I request an amendment from the person or entity that created the Protected Health Information. For example, if the information I wish to amend is in a medical report created by my health care provider, I must ask the provider to amend the report. I also understand that if the information is not available for my inspection, is not part of the plan's designated record set or is already accurate and complete, I cannot amend this information. I also understand that if the Plan determines that the PHI about which I am making this request is not part of a "Designated Records Set," meaning a group of records maintained by the Plan that is used to make decisions about individuals, that my request may be denied. My request may also be denied if the Plan determines that the PHI is information that I would not have the right to access under the law. The Plan may also deny this request if the Plan determines that the PHI for which I have requested an amendment is correct and complete without the amendment.

I understand that if my request for amendment is granted or partially granted, the Plan will notify me of the determination, and I will have an opportunity to specify any person or entity to whom information regarding the amendment should be sent.

I understand that if my request for amendment is denied or partially denied, I will be notified in writing of the Plan's decision and the reasons for the denial. I understand that if the Plan determines that my request should be denied, I will have the opportunity to submit a Statement of Disagreement to the Plan or request that this request be disclosed with all future disclosures of my Protected Health Information to which this request relates. If the Plan determines that my request should be denied, I will receive more information about the available options in the notification letter.

Right to request alternate means of communications

I understand that the Plan) may communicate my PHI to me in a variety of ways, including but not limited to, in person, by mail, by telephone, by facsimile, or by other means. I understand that I may request that this PHI be provided by alternative means at alternative locations. I understand the Plan will only accommodate reasonable requests and may require information as to how payment for my benefits or health care, if any, will be handled. I am making this request because disclosing all or part of my PHI by the usual means may endanger me and/or my health care.

NOTE: Until the Plan has agreed to your Request, the Plan may continue to communicate your Protected Health Information to you using any of the means listed above.

1. Is this a request to have your Protected Health Information communicated to you by mail only
YES NO
If YES, please provide the address of where would you like to have the Protected Health Information sent:

_____
_____

If NO, please provide complete the following information:

I am requesting that the Plan make the following accommodations with regard to how my Protected Health Information is communicated to me (please be specific):

2. This Request pertains to:
_____ All of my Protected Health Information
_____ The following Protected Health Information (please be specific):

Right to file a complaint

_____ By checking here, I am filing a complaint about how my PHI was handled. I am attaching a separate letter that includes the relevant details and the names of those involved.

_____ _____
Signature* Date Submitted

_____ _____
Signature of staff member accepting this form Date Accepted

* Where an individual is a minor, or is incompetent to enter into legally binding agreements due to mental, physical or other incapacity, the individual's parent, legal guardian, or other duly authorized representative must sign this request on behalf of the individual, and indicate the basis for his/her representation of the individual, e.g., parent of minor, legally appointed guardian, holder of power of attorney, etc.