Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Place Patient Label

RUSH

HIPAA PRIVACY REQUEST FOR RESTRICTION OF RELEASE OF INFORMATION

HIPAA Privacy Patient Rights

IDN13150017

You have the right under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to request that Rush University Medical Center (RUMC) or Rush Oak Park Hospital (ROPH) (collectively known as "Rush") restrict uses or disclosures of your health information to carry out treatment, payment or health care operations. Rush is not required under the law to agree to your requested restriction unless the request is regarding a disclosure of your health information to a health plan for purposes of payment or health care operations *and* the information relates to a health care item or service for which you have paid Rush out-of-pocket in full. Please complete this form if you wish to request a restriction on the use or disclosure of your health information. Please note that even if Rush restricts your information, Rush may use or disclose the restricted information if it is needed for emergency treatment. If Rush decides to terminate this restriction to the extent allowed by law, then Rush will provide you with any notice that is required by law.

Choose one:

_____ *This request is for a restriction that **does not** involve self-payment* ***(complete only page 1 of this form)***

_____ *This request is for a restriction for a service or item that **has been paid out-of-pocket and in full,*** ***(complete pages 1 and 2)***

Return the completed form to: **Rush University Medical Center, ATTN: Privacy Office, 707 S. Wood Street, Suite 317, Chicago, IL 60612, Phone: 312-942-4416; FAX: 312-942-6875.** Rush will respond in writing as to approval or denial of your request. You may also contact the Privacy Office with any questions about your request.

PERSONAL INFORMATION

Last Name	First Name	Middle Name
Street Address	City	State
Zip Code	Phone Number	Date of Birth
Patient Signature	Date of Request	Medical Record Number (if known)

(Optional) Personal Representative (if you are the patient's personal representative, please provide your information, below)

Last Name	First Name	Middle Name
Street Address	City	State
Zip Code	Phone Number	Date of Birth
Personal Representative Signature	Date of Request	Relationship to Patient

Please specify the type of protected health information you would like restricted and the dates of the information:

Date of Service **Clinic or Area Visited**

_____

_____

_____

Specific Service or Item to be Restricted

_____

_____

_____

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Place Patient Label

RUSH

HIPAA PRIVACY REQUEST FOR RESTRICTION OF RELEASE OF INFORMATION

Page 2: Restriction Request for Healthcare Service or Item that has been paid out-of-pocket and in full

If you want Rush to restrict information from being delivered to your health plan related to particular service(s) or item(s), you must complete this form. You must make a request to restrict disclosure of your information directly to each health entity/provider where you receive a health care service or item or that is involved with billing for the service or item. In some cases, even if you are on the Rush campus, you may receive treatment from a facility or physician that is not part of Rush and that will bill for services or items provided separately. *This restriction request will apply only to those health records created by Rush on the date that you received the service or item for which you made payment out-of-pocket and will apply only to disclosures to your health plan for payment or healthcare operations purposes.*

_____ **Initial here if you are requesting for Rush to restrict disclosure of information for a healthcare service or item from a health plan for which you have paid out-of-pocket, in full.**

Your signature below denotes your understanding and acceptance of the terms below:

I understand that I am required to pay my estimated bill in full at the time of service or this request will be considered invalid and my insurance may be billed by Rush without further notice. All remaining charges not included in this estimate but related to this item/service must be paid within a 30-day period from the date the item(s) and/or service(s) are provided; otherwise, my information will be released to my health plan so that reimbursement may be obtained by Rush.

I understand that I am required to provide current insurance information but that it will only be used by Rush if I do not meet the 30-day payment deadline outlined above. Health plans often require pre-certification for services. I understand that by making this request and choosing to pay out-of-pocket, I waive my right to obtain a pre-certification and that this will limit my ability to seek reimbursement from my health plan for the item(s) and/or service(s) subject to this restriction request if I later change my mind. Therefore, I understand that I will be responsible for the total balance due to Rush. If my payment for this service is declined or otherwise made invalid, I understand that Rush will make a good faith effort to contact me and obtain payment in another form within the 30-day period. If Rush is not able to obtain payment from me during the 30-day period, I understand that Rush may release information to my health plan in order to obtain reimbursement for care provided to me.

I understand that if the service or item for which I am making this request is part of a set of multiple services, Rush will determine whether it is possible to separate the charges for each service. For example, some services may be bundled together into a single charge (such as doctor's fee, lab fee, facility fee). If it is not possible to separate the charges, I understand that I may elect to pay for the entire set of services in order to implement this request and that if I do not pay for the entire set of services, Rush will bill my health plan. I further understand that even if services can be billed separately, a health plan may still be able to determine the nature of the unbilled service provided based on the context of other services submitted for payment. For example, if a patient paid for a physician visit related to a condition but his or her insurance plan was billed for medication for the condition, the health plan may be able to identify the condition based on the medication.

I understand that it is my responsibility to communicate to all other healthcare providers outside of Rush concerning my request for a restriction of disclosure to my health plan for services and treatment that I am paying for in full, out of pocket. I further understand that this form only covers Rush's portion of the bill and I will need to contact other providers, such as those listed below, to ensure none send my protected health information to my health plan:

MY PROVIDER – Physicians and nurse practitioners bill separately and I will need to contact their billing group(s) to obtain a restriction on their billings.	**PHARMACY** – I will need to ask my prescribing provider to provide me with a paper prescription, and I will need to make a restriction request directly to the pharmacy when I fill the prescription, to ensure that my medication is not billed or disclosed to my health plan.	**LAB** – I understand that some lab tests are done by an external vendor and I may have to contact one of them to obtain a restriction from their billing.

I understand that during future visits to Rush for care that relates to the services or items subject to this restriction request, healthcare providers may reference the services or items subject to this restriction in information that may be sent to my health plan to justify payment for those future visits. I understand that Rush will not redact or alter that information to reflect this restriction request, and that I can prevent such information from being disclosed to my health plan *only* if I pay out-of-pocket in full for services and/or items provided to me during future visits *and* complete additional restriction request(s). I also I understand that Rush will be unable to honor this request if information has already been released to my health plan. I further understand that this restriction request covers only the particular service(s) and/or item(s) provided to me during this visit.

Please note – when making this request, Page 1 information must also be provided

Name of Primary Insured | **Name and Address of Health Plan** | **Member ID#**

Member Group # | **Name of Person Responsible for Payment**

By signing below, I confirm that I have read and understand the statements above relating to a request for restriction of disclosure of my personal information to my health plan for a service or item for which I have paid out-of-pocket and in full.

Patient Signature | **Date of Request** | **Medical Record Number (if known)**