Request for Restricted Communications Policy
May 13, 2016

SCOPE
This policy applies to Florida Atlantic University’s Covered Components and those working on behalf of the Covered Components (collectively “FAU”) for purposes of complying with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

POLICY
To allow individuals the opportunity to request communications from FAU by alternative means or at alternative locations through a “Restricted Communications Request” Form in accordance with the HIPAA Privacy Rule.

REASON FOR POLICY
To establish a procedure by which individuals may request restricted communications from FAU.

DEFINITIONS- Refer to Glossary and Terms

PROCEDURE

1. Individuals have the right to request to receive communications from FAU by alternative means or at alternative locations through a “Restricted Communications Request” Form. For example, individuals may ask that appointment reminder calls be made to them only at work rather than at home. All reasonable requests should be accommodated.

2. FAU will not inquire why the individual is requesting communications on a confidential or restricted basis.

3. All reasonable requests are expected to be accommodated. If a request cannot be reasonably accommodated or if there are any questions or concerns with a particular request, the Chief Compliance Officer shall contact the individual in writing or by telephone to explain why the request cannot be accommodated.

4. All confidential communication requests that are approved must be documented. Before communicating with any individual, an FAU workforce member should determine whether a confidential communication or other restriction exists.
RESTRICTED COMMUNICATIONS REQUEST FORM

You have the right to request that Florida Atlantic University ("FAU") communicates with you on a confidential basis by requesting an alternative means or alternative location to receive FAU communications. All reasonable requests will be accommodated within FAU’s capabilities.

If you wish to be contacted at an address or phone number other than your home address or home telephone, please provide the following information:

Patient Name: __________________________________________________________________

Address to receive communications: ________________________________________________
______________________________________________________________________________

Telephone number to receive communications: _______________________________________

Please describe in as much detail as possible any other alternative means you request FAU use in communicating with you or any other alternative location not detailed above.
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Print Name: ______________________
Signature: ______________________
Date:  ______________________

If Authorized Legal Representative, relationship to patient: _____________________________

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FOR FAU USE ONLY:
Date Received: ________________

Request Approved ☐  Denied ☐  If denied, reason: _____________________________

Patient notified by:  ☐  Telephone  ☐  Letter  Date: _____________________________

Clinic representative: ____________________________
Signature: ____________________________ Date: ______________________

- PROVIDE COPY TO THE PATIENT AND MAINTAIN A COPY IN THE RECORD -