



**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: \_\_\_\_\_