

CHELAN-DOUGLAS RSN/PIHP POLICY AND PROCEDURE MANUAL		Chapter:	1.4.2.4
Title:	HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT	Page:	1 of 3
		Date Effective:	April 14, 2003
Subject:	Right to Confidential Communication	Date Revised:	April 14, 2003 October 21, 2011
		Authorizing Signature:	

AUTHORITY: Authorizing Source: RCW 70.02 45 CFR 164 (HIPAA)

SCOPE: This policy applies to Chelan-Douglas Regional Support Network/Prepaid Inpatient Health Plan (CDRSN/PIHP) and its contractors (agencies/providers), and subcontractors (referred to as contractors or agencies or providers throughout this policy).

PURPOSE: The Chelan-Douglas Regional Support Network, in compliance with the Privacy Rules of HIPAA's Administrative Simplification provisions, sets out, in this policy, the conditions for accommodating a consumer's request for confidential communications.

DEFINITIONS: See 1.3.2.0

POLICY: The Chelan-Douglas Regional Support Network will consider a consumer's request for confidential communications upon request for same.

We will use a Request for Confidential Communication of PHI form to document the alternative information and the approval. It will be our policy to grant reasonable requests. Reasonableness will be judged by the administrative difficulty of complying with the request.

We will not ask the client to explain why she/he wishes to have us communicate with them by alternative means or to alternative locations.

We will not comply with the consumer's request unless she/he have provided us with complete information to enable us to communicate with them – i.e., a complete address or other method of contact.

We will provide adequate notice of the request to those employees who may need to contact the client by flagging the record and, where possible, other client databases.

Procedures:

1. The consumer's right to confidential communication will be explained in the Privacy Notice.

2. Each client will be asked at the time of their initial contact if she/he wishes to exercise their right to confidential communication.
3. If confidential communication is requested, the request and approval should be noted on the client information. The following information will be included:
 - a. Is confidential communication being requested?
 - b. Is an alternative address to be used for communication?
 - c. Can postcards/letters identifying organization be sent to the alternative address?
 - d. If the address is not restricted can postcards or letters that identify the organization be sent there?
 - e. Is an alternative phone number to be used for communication?
 - f. Are there times of the day in which we are restricted from calling the client? List times.
 - g. Can we leave a message? Can the message list the name of agency/provider?
 - h. Can we leave a blind message with a phone number only?
4. Approval for a confidential communication can only be given if the client gives the organization adequate information to allow them to be contacted and makes adequate arrangements for services to be billed.
5. The following actions should be taken if a confidential communication has been requested and approved:
 - a. The outside of the record should be flagged with a sticker that states confidential communication.
 - b. Electronic records should have a field that flags the record as one where the client has requested confidential communication.
 - c. Any other client database, for example the billing database, should be flagged as well on the client contact screen and other appropriate screens.
6. Prior to contacting the client all employees should check one of the above to see if a flag exists. Employees who do not have access to any of the above three sources of information should not be responsible for contacting consumers.

SEE ALSO: Policies and procedures for confidential communications of PHI
Privacy notice
Administrative requirements – documentation retention

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Request for Confidential Communications Form

I, _____, request confidential communication of my health information when my health information is disclosed on my behalf.

Please use the following address or manner in disclosing my health information to me.
(Please be as specific as possible.)

Consumer Signature _____

Date _____

Printed Name and date of birth _____

Effective Date _____

Response to Request

_____ Agrees to entire request.

_____ Denies part of requested action.

_____ Requires more complete/specific information to assess your request.

_____ The CDRSN cannot reasonably accommodate your request.

Signed _____

Title: _____

Date _____