Employee Name: _____
Employee Id Number: _____ **Date:** _____

KEAP

Request for Restriction on Use or Disclosure of Your Protected Health Information

I. Your Protected Health Information

The Kentucky Employee Assistance Program (KEAP) is a confidential program designed to help employees and their families deal with problems that may affect job performance, their personal life, and their general well-being. KEAP assists employees and their dependents with getting help for any number of personal problems including substance abuse, depression, anxiety, marital problems, financial problems, and problems with parenting. Each person seeking assistance through KEAP receives a confidential assessment with a trained professional. The assessment may be conducted face-to-face or by telephone. Once a thorough assessment is conducted, the KEAP associate may make a referral to the most appropriate professional or resource and provide assistance in making contact with those resources.

Through the assessment/referral process, KEAP may collect and maintain protected health information ("PHI") that includes personal identifiers, insurance information, and health information. Pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), KEAP may use and disclose your PHI for treatment, payment, or health care operations including, but not limited to, patient referrals, claims processing, preauthorization, and case management. Other uses and disclosures permitted or required by HIPAA are outlined in KEAP's Notice of Privacy Practices.

II. Your Rights

You have the right to request KEAP to restrict uses and disclosures of PHI about you to carry out treatment, payment, or health care operations. You may also request KEAP to restrict uses and disclosures of your PHI to family members, relatives, close personal friends, or other persons identified by you who are involved in your health care or payment for that care.

KEAP is not required to agree to your requested restriction except when (1) the disclosure is for the purpose of carrying out payment or health care operations, (2) the disclosure is not otherwise required by law, and (3) the PHI pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid in full.

III. Request for Restriction on Uses and Disclosures of Your PHI

(a) I request to restrict:
(Check all that apply. For each restriction, check whether you want to restrict KEAP's use or disclosure or both.)

☐ KEAP's [☐ use] or [☐ disclosure] of my PHI regarding treatment.
☐ KEAP's [☐ use] or [☐ disclosure] of my PHI regarding payment for my health care
☐ KEAP's [☐ use] or [☐ disclosure] of my PHI regarding health care operations.
☐ KEAP's [☐ use] or [☐ disclosure] of my PHI to family members, relatives, close personal friends, or other persons identified by me who are involved in my health care or payment for that care.

(b) I request that the restrictions requested above apply to the following specific information:

_____
_____

Employee Name: _____
Employee Id Number: _____ Date: _____

(c) I request that the use and disclosure of the information described in (b) above be restricted in the following manner: _____

(d) I request that my PHI not be disclosed to the following individuals or entities:

_____

IV. Limitations and Termination of a Requested Restriction

If KEAP agrees to a restriction, either you or KEAP may terminate this restriction at any time. If KEAP informs you that it is terminating its agreement to a restriction, the termination of the restriction is only effective with respect to PHI created or received after KEAP informs you of the termination.

If KEAP agrees to a requested restriction on certain uses and disclosures, KEAP will notify you of such agreement and will not use or disclose PHI in violation of such restriction except where the restricted information is needed to provide emergency treatment. If restricted PHI must be used or disclosed to provide emergency treatment to you, then this restriction is void as it relates to this limited use or disclosure. If a restriction is agreed to by KEAP, it is not effective to prevent uses or disclosures required by the Secretary of the U.S. Department of Health and Human Services to investigate KEAP's compliance with HIPAA or uses or disclosures that are otherwise required by law. If a restriction is not specifically listed above and agreed to in writing by KEAP, it will not be effective.

V. Signature of Member or Member's Personal Representative *(Form MUST be completed before signing.)*

By signing below, I am indicating that I understand my rights regarding requested restrictions on uses and disclosures of my PHI. I also understand the limitations and termination provisions regarding my requested restrictions.

_____
Printed Name of Member

_____
Printed Name of Member's Personal Representative (If Applicable)

_____
Signature of Member or Member's Personal Representative

Date:_____

_____
If a Personal Representative – Describe Relationship to Member. Include authority/documentation proving status as a Personal Representative.

Remit Form To:

Sharron S. Burton, Privacy Officer
Office of Legal Services
Personnel Cabinet
501 High Street, 3rd Floor
Frankfort, KY 40601
Fax: (502) 564-7603
Sharron.Burton@ky.gov

VI. KEAP Response to Your Request for Restriction

In response to your request for a restriction on the use and disclosure of your PHI, KEAP:

☐ Agrees to the restriction as requested.
☐ Agrees to the restriction with modifications as follows:

_____
_____

☐ Does not agree to the restriction as requested.

_____
Signature of KEAP Privacy Officer

Date:_____
Date Copy Mailed to Member: _____