

# **SHORE HEALTH SERVICES, INC. – COMPLIANCE**

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## **OPTING – OUT OF THE FACILITY DIRECTORY**

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Effective: 5/04

Reviewed:

Revised:

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President / CEO

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Compliance Officer

**Purpose:** To facilitate compliance with the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, and any and all other Federal regulations and interpretive guidelines promulgated hereunder. To establish guidelines for the proper acceptance and processing of a patient's right to opt-out of the facility directory, as required by the HIPAA Privacy Standards.

**Policy:** The following information may be used to maintain a directory of individuals who are in the facility (the "Facility Directory" a.k.a. "Census") except when an objection is expressed by the patient:

- Patient's name;
- Patient's location;
- Patient's condition in general terms; and
- Patient's religious affiliation.

This information may be disclosed to:

- Members of the affiliated clergy (either in-house or community-based); and
- Other persons who ask for the patient by full name (only location may be disclosed).

Each patient must be notified of his or her right to opt-out of being listed in the Facility Directory in the Notice of Privacy Practices. A patient must request to opt-out and complete a Directory Disclosure Statement (sample attached) to invoke this right.

If the opportunity to object cannot be provided (*e.g., patient is incapacitated or in an emergency treatment circumstance*) the Facility Directory information may be used UNLESS the patient opted-out during his or her last encounter or, in the provider's professional judgment, it is necessary to opt-out the patient. As soon as reasonably practicable, the patient must be informed and provided the opportunity to object (*i.e., when the patient is able to receive the Notice of Privacy Practices*).

**Procedure:**

1. A patient's request to opt-out must be processed in conjunction with the receipt of the Notice of Privacy Practices.
2. Each patient who requests to opt-out must be informed of the effects of such decision (*e.g., no delivery of flowers, no visitors, etc.*), either verbally or in writing.
3. The Directory Disclosure Form must be completed to confirm the opt-out decision.
4. The decision to opt-out must be communicated to the Admission Supervisor or his or her designee to ensure the patient is flagged as confidential within the Affinity System.
5. The Privacy Officer or his or her designee must be notified that the opt-out request has been made and the confidential patient flag has been entered into the Affinity System.
6. The Admission Supervisor or his or her designee should route the opt-out request to appropriate departments. The notified departments should update patient records accordingly.
7. The Admission Supervisor, Privacy Officer, or appropriate designees should review the facility census and patient face sheet to ensure that appropriate privacy flags are present.
8. At a minimum, the individuals / departments to be notified shall include:
  - Nursing unit or ancillary department where patient is located;
  - Health Information Management (medical records);
  - Registration Supervisor or designee;
  - Director of Volunteer Services or designee;
  - Privacy Officer or designee.

**References:**

Standards for Privacy of Individually Identifiable Health Information 45 CFR Part 164  
Section: 164.510(a)

**Directory Disclosure Statement**

The Health Insurance Portability and Accountability Act of 1996 provides every patient with the right to limit the disclosure of their personal health information. Pursuant to those rights:

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*I hereby request that my name, general condition, religious affiliation, and location not be included in the Shore Memorial Hospital Directory. By invoking this right, I understand that anyone inquiring by phone or in person will be told by SMH staff : “I have no information about this patient.” No deliveries, including cards or flowers, will be forwarded to me.*

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Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Time: \_\_\_\_\_

Witness: \_\_\_\_\_

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*Shore Memorial Hospital Use Only:*

*Request processed by:* \_\_\_\_\_

	<u>initials</u>	<u>date</u>
<i>Notification of Admissions Supervisor</i>	_____	_____
<i>Notification of Privacy Officer</i>	_____	_____
<i>Notification of Volunteer Services</i>	_____	_____