Patient Right to Restrict Protected Health Information to Health Plan

Gundersen Health System
1900 South Avenue
La Crosse, WI 54601

Dear Patient,

You have the right to request restrictions on whether Gundersen Health System discloses (shares) your protected health information (PHI) with your health plan. **Gundersen Health System is required to agree to your request** unless *the information is required to be disclosed to your health plan to comply with the law.* However, if you are requesting a restriction on a service that has already been disclosed to the health plan prior to your request for the restriction, such as in the case of prior authorization requirements, by signing the form titled ***"Request: Restrict Disclosure to Health Plan"***, you acknowledge your awareness of this previous disclosure. Gundersen Health System will not share restricted PHI with your health plan but we will continue to share information with your providers. You are responsible for notifying all providers outside of Gundersen Health System not to disclose these services to your health plan. In the event that previously restricted PHI is required to satisfy your health plan's requirement for medical necessity, prior authorization, or payment of a subsequent service, and that subsequent service has not been restricted and paid for by you, Gundersen Health System is permitted to disclose such information. Therefore, if any of the previously restricted PHI would be part of a follow up visit at Gundersen Health System, you need to ask for the restriction again for that follow up visit. This would include the need to request the restriction for any related laboratory or radiology service if the restriction applies to those ancillary services as part of your visit.

Gundersen Health System is only required to honor your request not to disclose PHI to your health plan when:
You complete and sign the form titled ***"Request: Restrict Disclosure to Health Plan"***.

AND

At the time of service, you shall **pay out of pocket in full** the estimated cost of the service(s). If payment doesn't cover the full cost of service(s), you shall pay the remaining balance within 30 days of receipt of the bill for the service(s).
If approved, please bring your approved form with you at the service date in which you are requesting a restriction.

Gundersen Health System is not required to honor your request when:

You do not pay in full, as outlined above. We will terminate your request for the restriction and notify you of this termination via a letter. Termination will occur 30 days after the date of the letter. A copy of the letter will be stored in your medical record as validation of our termination of your original requested restriction.

OR

You request that the restriction be terminated. In order to terminate a previous request, you must contact the Gundersen Health System –Customer Financial Services Manager (608) 775-7234 to obtain your original ***Request: Restrict Disclosure of Health Plan/Termination*** form. Should termination occur, your insurance company may be billed for the service(s). If your insurance company has requirements that were not followed due to your original request for restriction, (i.e. timely filing, prior authorization and referral requirements, etc.), you will be responsible for any denial of payment from your insurance company, as well as any co-payments, deductibles or other charges for services not covered or paid by insurance or other third party payers.

Gundersen Health System
Revenue Cycle

REQUEST: RESTRICT DISCLOSURE TO A HEALTH PLAN

 I request that Gundersen Health System not disclose my protected health information (PHI) to my health plan or other third party insurance carrier.
 I have read the Patient Right to Restrict Protected Health Information to Health Plan form.
The records of the restricted services/items listed below will not be released or billed to my health plans for the purposes of payment or health care operations.
 I am financially responsible for these restricted services/items and expect to pay out-of-pocket, in full, at the time of service in order for Gundersen Health System to accept this restriction request.

Patient Name: ______________________________Date of Birth: ______________________

Address: _________________________________ MRN#: ____________________________

Date of service(s): ____/____/_____ - ___/____/_____Provider: ________________________
Services/Items to be restricted: ____
____

Total Charge Amount (or estimated amount): $_______________________________________
(I understand that I am responsible for full charges when finalized)

Name of Health Plan Restricted from Disclosure: ____

Signed by: _________________________________ Date: ___/___/____
☐Patient ☐Parent/Guardian ☐Representative (specify):___________________

Note: Gundersen Health System may terminate this restriction by notifying you in writing if you fail to pay in full.

When complete, forward to:
Gundersen Health System
Customer Financial Services Manager
1900 South Ave Mailstop NCA3-01
La Crosse, WI 54601

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FOR MANAGER USE ONLY:
Date Request Reviewed: _______________Position Titles of Reviewers: __________________________
Request above is: Approved__________________________Denied ____________________________
Reason for Denial: ____
(Payment in full not obtained, disclosure is required by law, Patient has Medicaid, Unable to unbundle services, etc)
Manager's Signature: ______________________________ Date: _______________
DATE COPY OF FORM MAILED TO PATIENT FOR APPROVAL/DENIAL:__________________________
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FOR INTERNAL USE ONLY:
Send original to Health Information Management Department, **mailstop AVS-001(ROI)**
HIM Dept. will scan into patient's medical records under doc type: Release of Information.
If Approved - HIM Dept. will add "restriction release" in the patient's ROI database.
Date Scanned: ____________________