



REQUEST FOR RESTRICTION ON USE AND/OR DISCLOSURE OF PHI

This form is used to make a request to restrict the use or disclosure of your Protected Health Information (PHI). Please complete the form and return a copy to Community Health Plan, Attention: Privacy Officer, 720 Olive Way, Suite 300; Seattle, WA; 98101. Please type or print neatly. We will not process incomplete or illegible forms.

Section A: Member Information

Member's Name _____ Birth Date _____

Street Address _____

City, State, Zip _____

Telephone # _____ Member # _____

If a personal representative is making this request on behalf of the member, please complete the following: (a personal representative is a parent of a dependent child under the age of 18 or a legally appointed representative, i.e., power of attorney or legal guardian.)

Personal Representative's Name _____ Relationship to Member _____

Section B: Please read the following and complete the information requested

You have the right to request that Community Health Plan restrict the use or disclosure of your PHI. Community Health Plan does not have to agree to your request. We will review your request and will notify you in writing of our decision. If we do agree to your request, in part or in whole, we will then restrict the agreed upon use or disclosure of your PHI, except that we may use or disclose the restricted information in a medical emergency when the information is needed for your treatment, or when you authorize us in writing to use or disclose the information, or when the use or disclosure is required or authorized by law.

The following is a description of the specific information I wish to restrict _____

I request that the following person(s) and/or organization(s) be restricted from the above information _____

The following is a description of why I am requesting the information be restricted _____

Section C: Agreement and Signature

I request that Community Health Plan restrict the use and/or disclosure of my protected health information as specified above. I understand that Community Health Plan is not required to agree to my request. I understand that the requested restriction will not be in force unless and until Community Health Plan informs me in writing that it has agreed to my request.

I understand that I may end the restriction at any time by notifying Community Health Plan in writing and that Community Health Plan may end the restriction at any time by notifying me in advance in writing. I also understand that if I terminate my coverage with Community Health Plan and then reinstate my coverage at a later date, I will need to request the restriction for my new coverage.

Signature _____ Date _____

Print Name _____

If a legal representative signs on behalf of the member, Community Health Plan must have a copy of the legal document declaring representation on file (i.e. power of attorney, legal guardian, etc).