COMMUNITY HEALTH PLAN of Washington™
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Community Health Plan of Washington
Request for Restriction(s) on the Use and Disclosure of Protected Health Information

I understand that I have the right to request restriction(s) as to how my protected health information (PHI) may be used and/or disclosed to carry out treatment, payment, or health care operations, or disclosed to family members and others involved in my care. I understand that Community Health Plan of Washington (CHPW) may not be required to agree to the restriction(s) requested. Even if my request for restriction(s) is denied, I will generally have the opportunity to agree or object prior to disclosures to persons involved in my care. If CHPW agrees to a requested restriction, it will be binding except in the case of emergency treatment. If restricted information is released for my emergency treatment, CHPW will request the provider not to further use and/or disclose that information.

1. **Member Name:** _____ **Date of Birth:** _____

Member ID Number: _____ **Date of Request:** _____

Member Address: _____

Member email: _____

Member Phone: _____ **Member Fax:** _____

Choose one: ☐ Ok to leave message with detailed information.
☐ Leave message with call-back number only.

2. I request the following restriction(s) on the use and/or disclosure of my PHI.

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3. I understand that CHPW will respond to this request within 30 days of the date of this request, unless CHPW extends the timeframe for an additional 30 days and provides me with a written statement for the reason(s) for the delay and the date by which I can expect a final response.

_____	_____	_____
Printed Name	**Phone**	**Date**

_____
Signature

☐ Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (e.g., Power of Attorney). This only applies if someone other than the member signed above.

Telephone Number of Personal Representative: _____

Personal Representative's relationship to the member: _____

4. Send the completed, signed request to:

Community Health Plan of Washington
Attn: Customer Service Department
1111 3rd Ave, Ste. 400
Seattle, WA 98101
Fax: (206) 521-8834
Email: CustomerCare@chpw.org

If you have any questions or to obtain a full notice of your privacy rights, contact CHPW's Customer Service department at the following

If you are a Washington Apple Health (Medicaid) Member	**If you are a CHPW Medicare Advantage Member**
Contact Customer Service toll-free at 1-800-440-1561, Monday – Friday, from 8am to 5pm. If you are hearing or speech impaired, please call TTY 711 (toll-free).	Contact Customer Service toll-free at 1-800-942-0247, 7 days a week, from 8am to 8pm. If you are hearing or speech impaired, please call TTY 711 (toll-free).

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The notice is also available online at: https://www.chpw.org/for-members/your-privacy-and-rights/	The notice is also available online at: https://medicare.chpw.org/member-center/member-rights/