Providence Health Assurance

MEMBER RESTRICTION TO RECORDS FORM

Complete this form to request a restriction of the uses and disclosures of your health information. Please use your Providence Health Assurance (PHA) member identification (ID) card to help you complete the information in Part A.

PART A: MEMBER INFORMATION *(Provide your name and personal information)*		
Member Last Name	Member First Name	Middle Initial
Member Date of Birth	Member Identification Number (see your ID card)	Group Number (see your ID card)
Member Home/Street Address	City, State, and Zip Code	Preferred Phone Number

PART B: TELL US WHAT INFORMATION YOU WOULD LIKE TO RESTRICT

☐ Revoke an existing restriction: _____ (Skip to Signature Section D)
Date of Revocation

☐ Limit what PHA shares with others involved in your care or payment, or limit information about your location, condition or death.

Please list the person(s) below and describe what information should be restricted:

Name: _____

Relationship to You: _____

Specify Restriction: _____

_____

PART D: MEMBER SIGNATURE AND DATE

I understand that PHA does not have to agree to my requested restriction(s). I understand this request will be reviewed and I will be informed if this request is accepted.

_____ _____

Member's Signature *Date*

_____ _____

Member's Designated Legal Representative/Guardian Signature *Date*

Relationship to Member: ☐ *Parent of a Minor* ☐ **Legal Guardian* ☐ **Power of Attorney*

**If this form is signed by someone other than the member, please attach authorizing legal documentation of guardianship or power of attorney.*

PART E: RETURN THE COMPLETED FORM TO PHA

Mail:	**Fax:**	Email:
Providence Health Assurance PO Box 4327 Portland, Oregon 97208-4327	503-574-8608	phpprivacyprogram@providence.org

If you have any questions, please call Providence Medicare Advantage Plans at 503-574-8000 or 1-800-603-2340. TTY users should call 711. We are open seven days a week, between 8 a.m. and 8 p.m. (Pacific Time). Between April 1st and September 30th, we are closed Saturdays and Sundays.

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What does my right to restrict my health information mean?
You or your personal representative have the right to request a restriction of the uses and disclosures of your protected health information maintained by PHA. You are only allowed to request a restriction of the uses or disclosures pertaining to treatment, payment, or healthcare operations; any other uses or disclosures required by law cannot be altered by PHA. Providence Health Plan understands the importance of keeping your health information confidential. We use and share only information that is necessary to provide services to you as permitted and required by law.

What do I need to understand to use this right?

- PHA will respond to your request within 30 days. If more time is needed (up to an additional 30 days), we will notify you in writing.
- You may ask us not to use or share your health information for certain purposes, such as treatment, payment, or health care operations. In most cases, we are not required to agree to your request. However, if you ask us not to share information with your health plan for payment or operations purposes and you have paid out of pocket in full for that specific service, we must agree to your request.
- We will let you know in writing whether we can agree to your restriction request.
- If we agree to a restriction, it will apply only to the information maintained by PHA.
- If you wish to restrict records held by your provider, please contact them directly.
- We cannot apply restrictions to information that has already been shared.
- If your request is approved, we will notify you in writing.
- If your request is denied, we will explain why and how you can respond in writing if you disagree.
- You may cancel the restriction at any time by contacting Customer Service.
- In an emergency, PHA may share information necessary to confirm your eligibility or coordinate your care.