Providence Health Plan

Information about Your Request to
Restrict Protected Health Information (PHI)

What does the right to restrict PHI mean?

You or your personal representative have the right to request a restriction of the uses and disclosures of your protected health information (PHI). Member or personal representative is only allowed to request a restriction of the use and disclosure pertaining to treatment, payment, or health care operations in accordance with the Health Insurance Portability and Accountability Act. Any other uses or disclosures that are required by law cannot be altered by the health plan. 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 our members and as permitted and required by law.

What do I need to understand to use this right?

- Providence Health Plan (PHP) will consider all requests for restrictions carefully; however, PHP is not required to agree to a requested restriction. Any restriction PHP accepts will be limited to the information under our control.
- PHP will try to accommodate all reasonable requests for a restriction, but reserves the right to deny a request if it would be infeasible to implement the restriction.
- PHP is not able to accept a request if it is made after the date of service occurred and information has already been released.
- If the request is granted, you will be notified in writing.
- If the request is granted it will be processed within seven (7) days of receipt of the request.
- The request for restriction may be denied and if so, you will be notified in writing of such denial.
- In situations where the member who requested the restriction is in need of emergency treatment, PHP may use professional judgment. If the member would benefit from overriding the restriction request due to an emergency, PHP will release the minimum necessary PHI to assist the provider in providing emergency treatment.
- A member may revoke this restriction in writing at any time by mailing or faxing the request to Customer Service Providence Health Plan, at the address listed below.

How do I restrict my PHI?

Enclosed is the Member Request to Restrict Protected Health Information (PHI). Please complete the entire form, sign it and return it to PHP. You may send your completed form to PHP at:

Mail:	Fax:	Deliver in Person:
Providence Health Plan PO Box 4327 Portland, Oregon 97208-4327	503-574-8608	Providence Health Plan 3601 SW Murray Boulevard Beaverton, Oregon, 97005 *Use main entrance on SW Murray Boulevard*

If you have any questions or concerns, you may contact your Customer Service Team at 888-231-9287 (toll-free). If you are hearing impaired and use a Teletype (TTY) Device, please call our TTY line at 711. Customer Service representatives are available Monday through Friday, between 8 a.m. and 5 p.m.

Non-discrimination & Communication Assistance | Providence Health Plan

Sincerely,

Providence Health Plan

Enclosure

Providence Health Plan

Member Request to Restrict Protected Health Information (PHI)

Use this form to request a restriction on the disclosure of Protected Health Information (PHI) in the Designated Record Set that Providence Health Plan (PHP) or one of its Business Associates maintains. If you need assistance completing the form, please contact the PHP Customer Service number listed on your member identification card. You must complete all the fields on this form.

MEMBER INFORMATION		
Member Last Name	**Member First Name**	**Middle Initial**
Member Date of Birth	**Member Identification Number (see member ID card)**	**Group Number (see member ID number**
Member Street Address	**City and State**	**Zip Code**

This request is (check one):

☐ New

☐ REVOKE an existing restriction effective (indicate MM/DD/YY)__________ skip to signature

Restriction Requested

☐ Restriction on use or disclosure relating to treatment, payment and/or healthcare operations. Please provide details

____

☐ Restriction on use and disclosure of PHI: (check all that apply)

☐ To a family member, other relative, or other identified person, directly relevant to their involvement with my care or payment for health care services. Provide details (e.g., restricted information and/or name of family member, friend)

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☐ Relating to my location, my general condition or my death to a family member, a personal representative or other person responsible for my care. Provide details (e.g., restricted information and/or name of family member, friend)

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Please note that, by law, we may be required to make the following types of disclosures, and so any restriction we agree to will not affect disclosures in the following circumstances or other circumstances where disclosures are required by law:

- Uses and disclosures for which an authorization or opportunity to agree or object is not required; such as in the cases of national security, public health activities, law enforcement, victims of abuse, neglect or domestic violence, research or other disclosures required by law;
- Disclosures required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with HIPAA.

MEMBER APPROVAL

By: ______________________________ Date: ____________________
Member's Signature

-OR-

By: ______________________________ Date: ____________________
Member's Designated Legal Representative/Guardian Signature

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 legal documentation if you are the legal guardian or holder of power of attorney.*