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.
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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:

Providence Health Plan
Attn: Customer Service PO Box 4327
Portland Oregon 97208-4327

You may fax your Member Request to Restrict Protected Health Information (PHI) to 503-574-8731 or 800-425-0199 or you may hand deliver it (if mailing, use only the post office box address listed above) to the following address:

Providence Health Plan Attn: Customer Service
3601 SW Murray Blvd. #10
Beaverton Oregon 97005-2359

Please Note: The enclosed Member Request to Restrict must be completed, signed and dated.

If you have any questions or concerns, you may contact your Customer Service Team at 503-574-7500 or 1-800-878- 4445. If you are hearing impaired and use a Teletype (TTY) Device, please call our TTY line at 503-574-8702 or 1- 888-244-6642. Customer Service representatives are available Monday through Friday, between 8 a.m. and 5 p.m.

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 your member ID card)**	**Group Number (See your member ID card)**
Member Street Address	**City and State**	**ZIP Code**

This request is (check one):

☐ New

☐ TO REVOKE an existing restriction effective (indicate MM/DD/YY)_____Skip to signature line

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 involvementwith my care or payment for health care services. Provide details (e.g., restricted information and/or name of family member, friend)

_____

☐ 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)

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 SIGNATURE AND DATE

By:_____ **Date:**_____

(Member Signature)

- OR –

By:_____ **Date:**_____

(Member's Designated Legal Representative/Guardian Signature)

Relationship to member: ☐ Parent ☐ Legal guardian* ☐ Holder of Power of Attorney*

***If this form is signed by someone other than the member or Parent, please attach legal documentation if you are the legal guardian or Holder of Power of Attorney.**

- ***Note: To parents/legal guardians of minors: state laws may prohibit Providence Health Plan from acting on your request about Sensitive Information without written authorization from the minor member. (Both parent and minor must sign.)***

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, religion, gender identity, martial status or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you are a member who needs these services, please call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan/Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, you can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH
Building Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-898-8174 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-898-8174 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-898-8174 (телетайп: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-898-8174 (TTY: 711).

Traditional Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-898-8174 (TTY: 711).

Kushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-898-8174 (TTY: 711).

Arabic: توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرید 1- 800-898-8174 (TTY: 711)

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-898-8174 (телетайп: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます. 1-800-898-8174（TTY: 711）まで、お電話にてご連絡ください.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-898-8174 (TTY: 711) 번으로 전화해 주십시오

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको िनम्तत भाषा सहायता सेवाहरू िननिःशुल्क रूपमा उपलब्ध छ । फोन गनुुहोस् 1-800-898-8174 (TTY: 711).

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați 1-800-898-8174 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-898-8174 (TTY: 711).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-898-8174 (TTY: 711).

Cambodian: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-898-8174 (TTY: 711)។

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ ທ່ານ. ໂທຣ 1-800-898-8174 (TTY: 711).