



### Member Request to Restrict Access to Designated Record Set

If you have questions, please contact Customer Service at 503-574-7500 (toll-free 1-800-878-4445; TTY 711

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

DOB \_/ \_/ \_- Member ID# \_\_\_\_\_ Group ID# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone \_\_\_\_\_

I understand I have the right to request Providence Health Plans (PHP) restrict the use or disclosure of my protected health information. PHP will attempt to honor my request although PHP is not legally obligated to do so. If PHP agrees to restrict access, I will be notified by PHP in writing.

Even if PHP agrees to my request, I understand PHP may continue to use or disclose the restricted information in a medical emergency when the information is needed for my treatment; when I authorize use in writing to use or disclose the information, or; when law requires the use or disclosure.

I may end the restriction at any time by notifying PHP in writing. PHP may end the agreement at any time by notifying me in writing. If I agree with PHP's decision to end the restriction, my protected health information will no longer be subject to the restriction. If I disagree, PHP's termination of the restriction will apply only to my protected health information that PHP receives after I received PHP's notice terminating the restriction.

I request sharing of the following protected health information be restricted:

\_\_\_\_\_  
\_\_\_\_\_

I request the restriction apply as follows:

\_\_\_\_\_  
\_\_\_\_\_

I request PHP restrict the use or disclosure of my protected health information as specified in above. I understand that PHP is under no obligation to agree to my request, and that there will be no agreement unless PHP informs me in writing that it agrees to my request.

\_\_\_\_\_  
Member or Representative's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Representative (if applicable)

\_\_\_\_\_  
Relationship to Member

#### For Office Use Only

Date Received \_/ \_/ \_- Sent To \_\_\_\_\_ Title \_\_\_\_\_ Date \_/ \_/ \_-

Restriction Request Accepted  Restriction Request Denied

By \_\_\_\_\_ Title \_\_\_\_\_ Date \_/ \_/ \_-

Member Notified:

By \_\_\_\_\_ Title \_\_\_\_\_ Date \_/ \_/ \_-

## 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, 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, 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 has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan 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 1-800-878-4445 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

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 1-800-878-4445 (TTY: 711)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오.

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

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。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អៗ គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

1-800-878-4445 (TTY: 711) ت ماس ب گ ير يد. شما براي رايگان بصورت زباني ت سه يلات ک نيد، مي گ ف تگوف ارسى بانز ب ه اگ ر: ت وجه

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

เตือน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)