Providence Health Plan | POWERED BY Collective Health

Revised 9/25

RESTRICTION REQUEST FORM

Collective Health is contracted by your employer-sponsored health plan ("Health Plan") to administer your Health Plan's benefits. Use this form to request from your Health Plan, that your Health Plan, Collective Health, and their business associates restrict uses or disclosures of your protected health information (PHI) to carry out treatment, payment, or health care operations, disclosure to persons involved in your health care or payment for health care, or disclosure to notify family members or others about your general condition, location, or death. This form can also be used to terminate a previously granted restriction request. Please complete all the fields on this form. We will coordinate with your Health Plan to respond to this request.

PLEASE UPLOAD THE COMPLETED FORM AS A NEW MESSAGE IN YOUR MY COLLECTIVE PORTAL OR MAIL TO US AT: COLLECTIVE HEALTH, ATTN: PRIVACY OFFICE, 1557 W. INNOVATION WAY, SUITE 300, LEHI, UT 84043.

Section A: Restriction request or termination of previous request:

Is this form being used to terminate a previously approved request for restriction? If "Yes", complete Section B, then proceed to Section D. If "No", complete all sections.

▢ **Yes -** Enter date to terminate previous request: _____ ▢ **No**

Section B: The individual who is requesting a restriction or termination. Please complete the following:

_____ _____ _____

Name **Subscriber ID #** **Date of Birth**

_____ _____ _____ _____

Address **City** **State** **ZIP**

_____ _____

Telephone Number **E-mail Address (if available)**

Section C: Please list the person(s) you want your PHI to be restricted from:

_____ _____

Name **Relationship to You**

_____

PHI You Want Restricted

If your request is granted, please make note of the following:

1. The request only applies to your current coverage. If any information about your coverage changes, including subscriber number or benefits (e.g., dental coverage is added), you must submit a new Restriction Request.
2. The request will expire once your benefits coverage has terminated.
3. Your Health Plan, Collective Health, and its business associates are only responsible for the PHI designated in Section C.

Section D: Signature - This document must be signed by the individual, parent of minor child or the individual's personal representative.

I request that my Health Plan, Collective Health, and their business associates restrict the use or disclosure of my PHI as specified in Section C above. I understand that my Health Plan is under no obligation to agree to my request. I understand I will receive a written determination regarding my request. I understand that if I am signing on behalf of a minor child, this request will expire upon the child reaching the age of 18, unless there is proof of continued legal authority.

_____ _____

Signature* **Date: month/day/year**

**If you are signing as a power of attorney, legal guardian, executor, or administrator, attach a copy of the legal documents granting authority.*