Providence Health Assurance | health share Health Share of Oregon

ProvidenceHealthAssurance.com/OHP

MEMBER RESTRICTION TO RECORDS FORM

Fill out this form to ask for limits on how your health information is used and shared. You can use your Providence Health Assurance (PHA) member ID card to help you fill out 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	503-584-4234	phpprivacyprogram@providence.org

You can get this form in other languages, large print, Braille or a format you prefer. You can also ask for an interpreter. This help is free. Call 800-898-8174 or TTY:711. We accept relay calls. Customer Service Representatives can be reached Monday through Friday between 8 am and 5 pm.

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What does it mean to limit my health information?

You can ask PHA to limit how your protected health information is used or shared. You can only ask for limits on information related to treatment, payment, or healthcare operations. PHA still has to follow the law with other uses or sharing. Providence Health Assurance cares about keeping your health information private. We use and share only what is needed to provide services to you as the law allows.

What should I know about using this right?

- PHA will answer your request within 30 days. If we need more time, up to another 30 days, we will let you know in writing.
- You can ask us not to use or share your health information for certain reasons, like treatment, payment, or health care operations. We don't always have to agree, but if you've paid for a service yourself, we must agree not to share that information with your health plan.
- We will tell you in writing if we can agree to your request.
- If we agree, the limit will only apply to the information PHA has.
- If you want to limit information held by your doctor, contact them directly.
- We can't change information that has already been shared.
- If we approve you request, we'll let you know in writing.
- If we say no, we'll tell you why and how you can reply if you disagree.
- You can stop the limit at any time by contacting Customer Service.
- In an emergency, PHA might share information needed to check if you qualify for care or to organize your care.