REQUEST TO RESTRICT USES OR DISCLOSURES OF PROTECTED HEALTH INFORMATION FORM

Purpose: This form is used for a Member's request to restrict uses and disclosures of the Member's Protected Health Information to carry out the Group Health Plan's own Treatment, Payment and Health Care Operations. As a health plan, the Group Health Plan does not perform any Treatment functions. Each Member requesting a restriction must complete a form. Please print clearly and complete Sections A and B. **Complete Section D only if applicable. The Group Health Plan is not required to grant the request.**

SECTION A: Member requesting restriction:

Member's Name: ____
First Middle Last

Member's Address: ____
Street Or P. O. Box City State Zip Code

Member's Date of Birth: _______/_____/______ **Subscriber** ID Number:_______________________
Month Day Year

Member's Telephone: ____________________ Member's E-mail *(optional)*:_______________________

SECTION B. Nature of requested restriction

I request my Group Health Plan or Business Associate(s) of the Group Health Plan, including ACS Benefits Services, Inc. ("ACS"), to restrict the uses and/or disclosures of the following Protected Health Information:

Restrict uses and/or disclosures of Protected Health Information for purposes of payment or health care operations in the following manner: ____

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SECTION C. Conditions governing the request for restrictions:

I. Under the Standards for the Privacy of Individually Identifiable Health Information (often called the "Privacy Rule"), a Group Health Plan and its Business Associate(s) are not required to agree to this Request to Restrict Uses or Disclosures of Protected Health Information ("Request), or the Group Health Plan and its Business Associate(s) may agree to only a part of the Request while denying agreement to the remaining Request.

II. If the Group Health Plan or Business Associate agrees to the requested restriction (whether all or in part), then the restriction is in effect until one of the following events occurs:

1. The Member agrees to, or requests in writing, that the restriction be terminated; or
2. The Group Health Plan or Business Associate notifies the Member that it is terminating the agreement to restrict the uses and/or disclosures of Protected Health Information.

SECTION C. Conditions governing the request for restrictions: *(continued)*

III. If the Member agrees to the termination of a restriction, then the Member's Protected Health Information will no longer be subject to the restriction. If the Group Health Plan or Business Associate terminates the agreement to restrict, then the termination is effective only with respect to information created or received after the date of notice of the termination of the restriction.

IV. The Member understands that if the Group Health Plan/Business Associate has agreed to a request for restriction, restricted Protected Health Information still may be disclosed to provide emergency treatment, but that the Group Health Plan/Business Associate will not further use or disclose restricted Protected Health Information for any other purpose.

V. The Member understands that he/she still has a right to (a) access Protected Health Information as allowed under the Privacy Rule and any other applicable law, and (b) receive an accounting of certain disclosures of Protected Health Information as explained in the Group Health Plan's Notice of Privacy Practices.

VI. The Member understands that restricted Protected Health Information may still be disclosed for public policy purposes as stated in the Notice of Privacy Practices.

Signature:____ **Date:** ____________________

SECTION D:

If signed by an individual other than the Member:

Print your full name: ____

Relationship To Member (i.e. parent, personal representative, etc.): ______________________________

Describe your authority to act for the Member (e.g. power of attorney, court order, parent of minor child, etc.):

____

You must attach the legal document naming you as the personal representative if you have not previously submitted it.

RETURN THIS REQUEST TO THE PRIVACY OFFICIAL AT THE OFFICE OF THE EMPLOYER

Received by: ____ Date: ______________

(Privacy Official – Employer's Office)

Employer's Name: ____

The Group Health Plan is not required to grant your Request. The Group Health Plan will deny a Request to restrict Uses and Disclosures of Protected Health Information if the restriction would prohibit the Group Health from carrying out its Treatment, Payment and Health Care Operations (TPO) activities. As a Health Plan, the Group Health Plan does not perform any treatment functions. The Group Health Plan acknowledges that there may be extraordinary situations in which it may be appropriate to grant a Request that affects the Group Health Plan's TPO functions. The Group Health Plan reserves the right to grant a Member's Request in such extraordinary situations, in consultation with ACS Benefits Services, Inc. before granting a request for restriction in whole or in part.

Timing of Response *– The Group Health Plan will respond to a requested restriction within an appropriate period of time, typically within sixty (60) calendar days.*