SGMC HEALTH PLAN RESTRICTION REQUEST

Purpose: This form is used for an individual's request to restrict use or disclosure of protected health information, including for treatment, payment, or health care operations.

SECTION A: Individual requesting restriction.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Member Number (From Ins Card): _____ Social Security Number: _____

SECTION B: To the Individual—Please read the following and complete the information requested.

You have the right to request that the Health Plan and its business associates restrict their use or disclosure of your protected health information, including for treatment, payment, or our health care operations. The Health Plan is under no obligation to agree to your request. If it does, the agreement must be in writing and will then restrict the use or disclosure of your protected health information as you request. The Health Plan may, notwithstanding the agreement, use or disclose the restricted information in an appropriate medical emergency when the information is needed for your treatment, or when you authorize the Health Plan in writing to use or disclose the information, or when the use or disclosure is required by law.

You may end the restriction at any time by notifying the Health Plan in writing. The Health Plan may end the agreement to restrict use or disclosure of your protected health information at any time by notifying you in writing. If you agree with the decision to end the restriction, your protected health information will no longer be subject to the restriction. If you disagree, the termination of the restriction will apply only to your protected health information that the Health Plan received after we gave you notice terminating the restriction. To exercise your right to request restriction on the use or disclosure of your protected health information, please complete this Section B.

Please specify the protected health information, the use or disclosure of which you want to restrict:

_____

_____

Please state the restriction you want to apply to that protected health information:

_____

_____

SIGNATURE.

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

Signature: _____ Date: _____

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS REQUEST.

Return completed form to SGMC Human Resources. Fax: 229-259-4701