Health Partners Plans

Request for Restriction of Use and Disclosure of Protected Health Information

Use this form to request a restriction on use and disclosure of your Protected Health Information (PHI).

INSTRUCTIONS FOR COMPLETING THIS RESTRICTION FORM

Health Partners Plans members have the right to request that Health Partners Plans (HPP) restrict the use or disclosure of health information for certain aspects of treatment, payment, or health care operations. Members also have a right to request that HPP restrict the disclosure of their health information to family members and others involved in their care. HPP will consider all requests for restrictions carefully; however, HPP is not required to agree to a requested restriction.

Part 1: Member information. This section should name the HPP member whose PHI is requested. Print the member's name, birth date, address, telephone number, and Member ID number.

Part 2: Restriction. In this section provide information about the restriction you would like to take place.

Part 3: Review and approval. The *member's* signature is required. If the member is incapable of signing, a personal representative may sign on the member's behalf. Parents or guardians of minors will be confirmed using information from the state. A personal representative such as an executor or someone with a power of attorney may sign his or her name in the member's place. The legal documents proving the authority of the personal representative to act for the member **MUST** be attached or on file at HPP; otherwise, the personal representative's signature will be invalid, and this form will **NOT** be processed.

Complete ALL sections. If information on this form is not complete, Health Partners Plans will return the form and will not consider this request until it has received complete information.

CONTACT INFORMATION

RETURN YOUR FORM(S) TO THE ADDRESS LISTED BELOW

If you have any questions or need assistance in completing this form, call the Member Relations telephone number on the back of your identification card or write to:

Health Partners Plans
Privacy Services
1101 Market Street, Suite 3000
Philadelphia, PA 19107
or
Fax: 267-515-6666

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All fields are required.

Part 1: Please PRINT the requested information below

Member Name:	Date of Birth:
Address:	City/ZIP:
Member ID #:	Telephone:

Part 2: Restriction requested

A. Select the protected health information to be restricted:

☐ Restriction of record release to a Payer
☐ Restriction of record release to an Attorney
☐ Restriction of record release to a Family member/s
☐ Restriction of record release to a Health Information Exchange
☐ Other: The information I want to restrict is _____.

B. Persons/organization restricted from uses/disclosure:

Person's or organization Name:	Relationship to Member:
Address:	Telephone:
	Fax:

Part 3: Signature

You have the right to request that Health Partners Plans (HPP) restrict its use of your PHI to what is necessary for the provision of health care or payment of claims. HPP participates in Health Information Exchanges (HIEs) which, through secure connected networks with health care providers who participate in the HIEs, makes it possible for us to electronically share protected health information to coordinate patient care. We may electronically share your medical information through HIEs, among participating HIE members for the purposes of treatment, payment, health care operations, and other authorized purposes, to the extent permitted by law.

You have the right to ask HPP to restrict the use and disclosure of your protected health information (PHI) for Treatment, Payment, or Health Care Operations except for uses or disclosures required by law. You have the right to ask HPP to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care. You also have the right to restrict the use and disclosure of health information to notify those persons of your location, general condition, or death – or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request must be in writing. HPP is not required to agree to your request and is not permitted to grant restrictions that violate the law. If HPP agrees to your request, then we will be bound by the restriction unless the restriction is later ended by your written request. HPP may also release the restricted information if you require emergency treatment, or to comply with the law. Depending upon the nature your request, it may take several days to respond. Until your request has been accepted, HPP will use and disclose your health information in a manner consistent with our Notice of Privacy Practices and applicable law. If HPP grants your request, you will be notified in writing. Restrictions will expire for minors when they reach the age of maturity (18 years of age).

Part 3: Signature

I have read and understand the above information:

Member or personal representative name (please print): _____.

Signature: _____ Date:_____.

If you are a personal representative, state your relationship to the member:_____.

Note that, if not already provided, we will require verification of the authority of a personal representative such as a copy of a health care, general or durable power of attorney before this request will be considered complete.

If this request is made by a parent/guardian, complete the following:
Member/participant is a minor ____ years of age*. If you are making this request on behalf of a minor child, we may require additional information such as a court order or other documentations that shows custody or other legal document showing the authority of the legal representative to act on the member's behalf before this request is considered complete.*