Restriction to Use or Disclosure of PHI Request Form

Western Health Advantage

Mail to: Western Health Advantage Mail Service, Attn: Member Services
PO Box 4457, Portland, OR 97208-4457
Fax to: 916.678.5440
Questions? 916.563.2250 | 888.563.2250 toll-free | 711 TTY

Member Information

First Name _____ Last Name _____ MI _____

WHA Member ID#_____ Date of Birth _____

Address_____ Apt./Unit#_____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

This form will allow a member to request for a restriction on the use and disclosure of Protected Health Information (PHI) or to revoke the restriction placed on the use or disclosure of PHI. Western Health Advantage (WHA) will consider all request for restrictions carefully, however, WHA is not required to agree to a requested restriction. Any restriction WHA accepts will be limited to the information under our control.

This request is (check one):

❏ New ❏ Modified

❏ TO REVOKE an existing restriction effective (indicate MM/DD/YY)_____ Skip to signature line

Restriction Requested

❏ Restriction on use or disclosure relating to treatment, payment and/or healthcare operations.
Please provide details _____

❏ Restriction on use and disclosure of PHI: (check all that apply)

- ❏ To a family member, other relative, or other identified person, directly relevant to their involvement with my care or payment for health care services. Provide details (e.g., restricted information and/or name of family member, friend) _____
- ❏ Relating to my location, my general condition or my death to a family member, a personal representative or other person responsible for my care. Provide details (e.g., restricted information and/or name of family member, friend) _____
- ❏ A passcode or personal identification number (PIN) when calling WHA to further secure the account (fill up Account Passcode/PIN Request Form to provide details)

❏ Other restrictions on use or disclosure. Please describe details _____

I understand and agree to the following:

- If my request is granted, WHA may not use or disclose the PHI in violation of the restriction except as noted below. This request for restriction may be denied and if so, I will be notified in writing of such denial.
- Any restriction agreed to by WHA is not effective to prevent uses or disclosures permitted or required under the HIPAA Privacy Rule, including: for the emergency treatment of the individual whose PHI is under restriction; disclosures to the Secretary of Health and Human Services; or disclosures for which consent, authorization or opportunity to agree or object is not required.
- If this request is granted, it will be processed within seven (7) days of receipt of the request by electronic transmission or within 14 days of receipt by first-class mail.
- I may revoke this restriction in writing at any time by mailing or faxing the request to Member Services, Western Health Advantage, at the address listed at the top of this form. The termination will be effective with respect to any PHI created or received **after** the termination date.
- This request must be accompanied by a copy of a photo ID of the person signing the form, unless one is already on file with WHA.

WHA Member Signature _____ Date _____

Print Name _____

Personal Representative Signature _____ Date _____

Print Name _____

Please check the box that describes your relationship to the member/enrollee:

❑ Parent of Minor ❑ Legal Guardian ❑ Power of Attorney ❑ Executor

❑ Other _____

Documentary proof of your relationship/authorization must be attached to this request, otherwise it cannot be processed or may be denied. If you are requesting the restriction on behalf of a minor, federal and state laws may prohibit WHA from acting on your request about information relating to sensitive services without written authorization from the minor 12 years of age or older. If the restriction will prevent the child's other parent from accessing PHI, you must either provide evidence that the parental rights of the other parent has been terminated, or obtain the other parent's signature to this restriction form and have it notarized.

Keep a copy of this for your records.

WHA Internal Use Only

Date Request Received _____ Date Request Fulfilled/Denied _____

❑ Identification Verified (documents checked)

If Denied, reason for denial _____

Signature of Manager or Supervisor _____

Printed Name _____