HEALTH INFORMATION RESTRICTION REQUEST

HEALTH INFORMATION RESTRICTION REQUEST

Member requesting restriction:

Name: ____

Member ID: ____

Address: ____

Telephone: ____

Please read the following and complete the information requested:

You have the right to request that we restrict our use or disclosure of your protected health information. **We are under no obligation to agree to your request. If we do, our agreement must be in writing and we will then restrict our use or disclosure of your protected health information as you request.** However, we may use or disclose the information in an appropriate medical emergency when the information is needed for your treatment, or when you authorize us 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 us in writing. We may end our agreement to restrict use or disclosure of your protected health information at any time by notifying you in writing. If you agree with our decision to end the restriction, your protected health information will no longer be subject to the restriction. If you disagree, our termination of the restriction will apply only to your protected health information that we receive after we gave you our notice terminating the restriction. To exercise your right to request restriction on our use or disclosure of your protected health information, please complete this Section.

Please specify the protected health information that you want us to restrict from use of disclosure:

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PLEASE CONTINUE ON TO THE NEXT PAGE

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Member's Signature

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

Member Signature: ___________________________________

Date: ___________________________________

If a person other than the member completes this form:

Personal Representative's Name:

____

Relationship to individual:

____

YOU ARE ENTITLED TO A COPY OF THIS REQUEST

Please address your request to:

Privacy Officer

Partnership HealthPlan of California

4665 Business Center Drive

Fairfield, CA 94534

OR

By FAX to 707-863-4117, Attention: Privacy Officer