HCS
HEALTH COST SOLUTIONS

100 BLUEGRASS COMMONS, SUITE 200
HENDERSONVILLE, TN 37075
PHONE: 615-822-0483

Request for Restrictions on Use or Disclosure of Protected Health Information

I. Individual Data:

INDIVIDUAL'S NAME:_____
GROUP HEALTH PLAN ID NUMBER: _____
ADDRESS:_____
TELEPHONE NO.:_____

II. Nature of Requested Restriction:

I request my GROUP HEALTH PLAN ("GHP") or its Business Associate to restrict the use and/or disclosure 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: _____
(e.g., do not use my protected health information to audit GHP's preferred providers)

☐ Restrict disclosures to a family member, relative, or close personal friend who is involved with my health care. Please specify individual(s) to whom this restriction applies: _____
_____

III. Conditions Governing the Request for Restrictions:

A. Under the Standards for the Privacy of Individually Identifiable Health Information (often called the "Privacy Rule"), a GHP and its Business Associate are not required to agree to this Request for Restriction, or they may agree to only a part of the Request for Restriction, while denying agreement to the remaining request.

B. If the GHP or Business Associate agree to the requested restriction (whether all or in part), then the restriction is in effect until one of the following events occurs:

1. Individual agrees to, or requests in writing, that the restriction be terminated; and

2. GHP or Business Associate notifies Individual that it is terminating the agreement to restrict the uses and/or disclosures of protected health information.

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C. If Individual agrees to the termination of a restriction, then Individual's protected health information will no longer be subject to the restriction. If GHP 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.

D. Individual understands that if GHP/Business Associate has agreed to a request for restriction, restricted protected health information still may be disclosed to provide emergency treatment, but that GHP/Business Associate will not further use or disclose restricted protected health information for any other purpose.

E. Individual understands that he/she still has a right to access protected health information as allowed under the Privacy Rule and any other applicable law.

F. Individual understands that he/she may receive an accounting of certain disclosures of protected health information as explained in GHP's Notice of Privacy Practices.

G. Individual understands that restricted protected health information may still be disclosed for public policy purposes as stated in the Notice of Privacy Practices.

INDIVIDUAL SIGNATURE: _____

INDIVIDUAL NAME (Please Print):_____

GHP/BUSINESS ASSOCIATE TO COMPLETE THE FOLLOWING:

The Request for Restriction is: ☐ Accepted* ☐ Denied

*If Request is accepted *in part*, describe the restriction to be implemented:
_____.

Date Restriction Becomes Effective: _____.

Signature of GHP/Business Associate Representative: _____

Date _____