Sentara Health Plans

REQUEST FOR RESTRICTION OF USE AND DISCLOSURE

This form is to request a restriction, or limitation, on the use and disclosure of your Protected Health Information ("PHI").

Sentara Health Plans members have the right to request that Sentara Health Plans restrict the use or disclosure of health information for treatment, payment or health care operations. Members also have the right to request that Sentara Health Plans restrict the disclosure of their PHI to family members and others involved in their care. Sentara Health Plans will review all requests for restrictions carefully. However, Sentara Health Plans is not required to agree to a requested restriction.

Please provide the following information:

Date: _____ Member Name: _____

Date of Birth: _____/ _____/ _____Member ID Number: _____

The specific information I am requesting to be restricted is:

_____

_____

I request that this restriction apply to the following uses and disclosures (who do you want to restrict from getting or using the information?):

_____

_____

I request that my information may not be accessed, discussed, or restricted, without successful presentation of a password, which I have selected.

The password to be used for all access is: _____

I understand that I have a right to request that Sentara Health Plans restrict its use of my PHI to what is necessary for the provision of health care or payment of claims.

If the request is granted, you will be notified in writing. However, Sentara Health Plans may use or disclose the restricted information when needed to treat you in a medical emergency or when required by law.

If my restriction is approved, I may end this restriction at any time by writing to Sentara Health Plans at the address or email below. Restrictions requested and approved for minors expire on the minor's eighteenth (18th) birthday.

I further understand that Sentara Health Plans will respond to this request in writing and that use, and

disclosure of the PHI will not be restricted unless I receive approval from Sentara Health Plans.

Mail or email this completed request form to: Sentara Health Plans Compliance
PO Box 66189
Virginia Beach, VA 23466
shpprivacy@sentara.com

Privacy Statement: Please be aware that email and text communication can be intercepted in transmission or misdirected.

_____ _____
Signature of Requestor Date

_____
Printed Name of Requestor

Note: if your request is granted, it will apply only to written and oral communications by Sentara Health Plans. Sentara Health Plans cannot agree to restrictions on behalf of non-Sentara Health Plans insurance companies or health care providers.

If you are requesting restriction on behalf of someone other than yourself, please enclose proof of your authority to do so (i.e., guardianship order, custody order, court order) as appropriate.

Definitions

Member: The person who is subject of the protected health information.

HIPAA Authorized Representative: Someone who has the legal authority to act on an individual's behalf to make decisions about that person's health care. Parents may be HIPAA Authorized Representatives for minors, except those minors who have been given the legal freedom to act on their own. HIPAA Authorized Representatives may include guardians, conservators and other persons who have been given legal responsibility for another individual. Federal law, state law, and the specific terms of the appointment determine the authority granted to the HIPAA Authorized Representative.

Member Identification [(ID)] Number: The number assigned to an individual by a health plan. Sometimes it is the individual's social security number.

Password: This is a combination of letters and/or numbers which is selected by the member and is to be used to identify the person requesting information.