Instructions to complete the Highmark Health Options Member Request for Restriction on Uses and Disclosures of Protected Health Information Form

Section A: Member Information

1. Write the first and last name of the member whose information is being restricted.
2. Write the member's identification number.
3. Write the member's address.
4. Write the member's date of birth.
5. Write the member's telephone number.

Section B: Health Information to be disclosed

1. Write the information or records you want restricted.
2. Write the name of the person or organization to which the restriction should apply.
3. Write the dates you would like this restriction applied.
4. Write the reason for this request.

Section C: Signature

1. This form must be signed and dated by the member whose information is to be restricted.
2. If the member is unable to sign this form, a personal representative with legal authority on file with Highmark Health Options may sign and date the form. If a personal representative is signing the form on the member's behalf:
    a. Insert the personal representative's relationship to the member.
    b. Insert the personal representative's telephone number.
    c. Insert the personal representative's address.

Section D: Personal Representatives

If you are completing this form on behalf of a Highmark Health Options member please indicate in this section the legal authority that gives you this right (i.e. Personal Representative form, Healthcare Power of Attorney, legal guardianship, etc.).

If you have not already done so, you will be required to complete an Authorization to Use and Disclose Form and submit it to Highmark Health Options. If the form is not on file when we receive this form, the request will be denied. The form can be obtained and returned in the same manner as the Restrictions Request Form.

HIGHMARK HEALTH OPTIONS

Member Request for Restriction on Uses and Disclosures of Protected Health Information

Section A: Member Information (Please Print)	
Member Name:	Member ID:
Address:	
Date of Birth:	Telephone:

Section B: Restriction Requested:

Please describe the information or records you want restricted (e.g., pregnancy test results):

Please tell us the name of the person or organization to which the restriction should apply:

Please specify the dates of you would like this restriction applied:

Start date: ____/____/_____ End date: ____/____/_____

Please tell us the reason for this request:

Section C: **Signature**

I understand that I have the right to request that Highmark Health Options restrict the uses and disclosures of the Protected Health Information created or kept by Highmark Health Options under some circumstances.

I understand that Highmark Health Options will review my request after receipt of this completed form, however, Highmark Health Options may not be able to honor all requests and still provide your care. Highmark Health Options is not required to agree to all restrictions requested by members.

I understand that until a decision is reached, my request for restriction will not be honored.

PLEASE FILL OUT THE REVERSE SIDE OF THIS FORM

I understand that any form returned to Highmark Health Options incomplete will be returned to me for completion and my restriction request will not be implemented until all the information is received complete and processed.

I understand that I do not have the right to restrict the use or disclosure of information required by law; needed for public health activities; related to abuse, neglect or domestic violence; used for health oversight activities; needed for judicial and administrative proceedings; needed for law enforcement purposes; needed to avert a serious threat to health or safety; needed for specialized government functions; or needed for workers' compensation programs.

I understand that if Highmark Health Options denies this request, I may have the right to request a reconsideration of the denial decision. I must submit my request for reconsideration in writing to:

Privacy Department
Highmark Health Options
PO Box 890419
Camp Hill, PA 17089

Signature: _____ Date: _____

If this authorization is signed by someone who is not the member listed at the top of this form, attach any documents (i.e. general power of attorney) that verify the signer's authority to act for the member.

Section D: If you are a Personal Representative filling out this form for a Highmark Health Options member, please write that relationship below and the legal reason that gives you this right (i.e. Power of Attorney, guardian, etc.). If you have not done so, you will be required to fill out an Authorization to Use and Disclose Form and send it to Highmark Health Options. You can get the form and return it in the same way as the Restriction on Uses and Disclosures Request Form.

If you are not the member, print your name:	Relationship to member:
Legal form on file:	Telephone number:
Address:	

HIGHMARK. HEALTH OPTIONS

Discrimination Is Against the Law

Highmark Health Options complies with applicable Federal civil rights laws and regulations and does not discriminate on the basis of race, color, national origin, age, disability, health status, sex, sexual orientation or gender identity. Highmark Health Options does not exclude people or treat them differently because of race, color, national origin, age, disability, health status, sex, sexual orientation or gender identity.

You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Help in Your Language

Highmark Health Options provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, Braille, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, se encuentran disponibles servicios de asistencia con el idioma sin costo alguno para usted. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711).

Si w pale kreyòl ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou do kat idantifikasyon w lan (TTY: 711).

注意：如果您讲中文，可以免费为您提供语言协助服务。拨打您的 卡背面的号码（听障人士专用号码：(TTY: 711）。

注：英語を話す場合は、無料の言語支援サービスを利用できます。 あなたのIDカードの裏面（：711 TTY）の番号を呼び出します。

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ તો, તમારા માટે ભાષા સહાયતા સેવાઓ મફતમાં ઉપલબ્ધ છે. તમારા આઇડી કાર્ડની પાછળ આપેલા નાંબર પર ફોન કરો (TTY: 711).

ATTENTION: Si vous parlez français, des services d'assistance linguistique vous sont offerts gratuitement. Veuillez appeler le numéro qui se trouve au verso de votre carte d'identification (TTY : 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 카드 뒷면의 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: Se parla italiano, per Lei sono disponibili servizi di assistenza linguistica gratuiti. Chiami il numero presente sul retro della Sua carta di identificazione (TTY: 711).

LƯU Ý: Nếu quý vị nói Tiếng Việt, luôn có các dịch vụ hỗ trợ ngôn ngữ được cung cấp miễn phí cho quý vị. Vui lòng gọi số điện thoại trên mặt sau của thẻ nhận dạng của quý vị (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen kostenlose Unterstützung in Ihrer Sprache zur Verfügung. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TYY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, may maaari kang kuning mga libreng serbisyo ng tulong sa wika. Tawagan ang numero sa likod ng iyong card (TTY: 711).

कृपया ध्यान दें: यदि आप हिन्दी बोलते है, तो भाषा सहायता सेवाएं आपके लिए निशुल्क उपलब्ध है। अपने पहचान कार्ड के पीछे दिए गए नंबर पर कॉल करे (TTY: 711)।

توجہ دیں: اگر آپ اردو بولتے/بولتی ہیں تو، آپ کے لیے زبان کی اعانت کی خدمات مفت دستیاب ہیں۔ اپنے آئی ڈی کارڈ کے پیچھے درج نمبر پر ہمیں کال کریں (ٹی ٹی وائی: 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل على الرقم المدوّن على ظهر بطاقة هُويتك (الهاتف النصي: 711).

గమనిక: మీరు తెలుగు మాట్లాడే వారైతే, భాషా సహాయక సేవలు, ఖర్చు లేకుండా, మీరు లభిస్తున్నాయి. మీ ఐడి కార్డుకు (TTY: 711) వెనుక వైపు ఉన్న నంబర్‌కి ఫోన్ చేయండి.