

Request to Restrict Use and/or Disclosure of Protected Health Information

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), individuals have the right to request that a health plan restrict the use and/or disclosure of their Protected Health Information (PHI). However, the regulations do not require that the request be honored. We understand the importance of maintaining the confidentiality of our members' health information. As a result, we use and disclose member level information only as necessary to provide services to our members and as permitted and required by law. Therefore, we are unable to honor most requests to further restrict the ways in which we use and/or disclose individually identifiable health information. To do so would seriously impair our ability to provide quality benefits to you. We will consider all restriction requests, but will only be able to honor extraordinary ones. This is why we ask you to describe the reason(s) for your request.

When completing this form, please:

- Complete all sections entirely;
- Print information clearly;
- Provide us with your most current information.

Please note: If you are a guardian or court appointed representative for the individual you must attach copies of your authorization to represent the individual in order to obtain access to their PHI.

Please note that entities can only process restriction requests with respect to benefits and programs they administer. To process a request for restriction of your PHI beyond your behavioral health and Employee Assistance Program (EAP) healthcare information covered by this form, you must contact each entity that administers your benefit directly.

This Request to Restrict Use and/or Disclosure of Protected Health Information form is for use by UnitedHealthcare and Optum members and their personal representatives. UnitedHealthcare behavioral health benefits are managed by Optum.

Request to Restrict Use and/or Disclosure of Protected Health Information (PHI)

This form is used to request a restriction on the way we use and/or disclose PHI contained in your Designated Record Set. Once the decision to grant or deny your request has been made, a letter will be mailed to you or your authorized personal representative. Please print.

Section 1: Restriction Requested For:

Name _____ Address _____

City _____ State _____ Zip _____

Phone Number (_____) _____ Date of Birth _____ Male ___ Female ___

Relationship to Subscriber: Self ___ Spouse ___ Child ___ If other, describe type of relationship _____

Section 2: Specific Restriction Requested:

Please indicate the way(s) in which you would like us to restrict use and/or disclosure of your PHI and the specific reason(s) for your request.

Section 3: Signature of Member or His/Her Personal Representative:

Authorized signature of individual or personal representative of individual for whom the restriction is being requested:

Signature of Individual: X _____ Date _____

Signature of Personal Representative if applicable: X _____ Date _____

Representative's Name _____ Address _____

City _____ State _____ Zip _____ Phone Number (_____) _____

Relationship to individual and authority to act for individual _____

Important: A personal representative, including a parent, legal guardian or executor of an estate may be required to attach a copy of legal documentation to this request form.

Section 4: Subscriber Identification:

Subscriber Identification Number _____ Group Number _____ Employer _____

Subscriber Name _____ Address _____

City _____ State _____ Zip _____ Phone (_____) _____

Please return the completed form to:

Fax: 888-371-7011

Or

Mail to:

Privacy Administrator

MN101-E013

11000 Optum Circle

Eden Prairie MN 55344