GlobalHealth

REQUEST TO LIMIT USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION ("PHI")

Name: _____ Date of Birth: _____

Member ID #: _____ Phone Number: _____

Address: _____

Please describe in detail what you are requesting including the date(s), type of record, and what uses and/or disclosures you want to limit. Attach additional pages if necessary.

_____

_____

_____

NOTICE: The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") allows you to request a limitation on the use and/or disclosure of your Protected Health Information ("PHI"). We are not required to honor all requests. Please use this form to describe the limitation you are requesting. If we agree to your request to limit use and/or disclosure of your PHI, it will be effective on the date this form is signed, but will not apply to any uses or disclosures we have made prior to this date.

Understanding and Acknowledgement

I acknowledge that the limitation or restriction I am requesting may be refused for reasons permitted under HIPAA. If making this request for someone other than myself, I certify I am the individual's legally authorized personal representative and am requesting this limitation or restriction in good faith and in the best interest of the affected individual. I understand GlobalHealth may require documentation establishing legal authority of the personal representative for the above named Member, including but not limited to, durable power of attorney for health care.

_____ _____

Signature of Person Submitting Request Date

_____ _____

Printed Name Relationship to Patient/Member

For Facility Use Only:

Date Received: _____ Restriction has been: ____ Accepted ____ Denied

_____ _____

GlobalHealth Representative Date

MRLUDPHI 03/2013