blue of california

REQUEST FOR RESTRICTION OF USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use this form to request that a restriction be placed on Blue Shield of California's use or disclosure of your protected health information ("PHI") for certain permissible purposes, including, for example, carrying out treatment, payment, or health care operations, or disclosing your PHI to family members or others involved in your care. **Blue Shield of California is not required to agree to your request for a Restriction.** We will notify you in writing as to whether your request has been granted or denied. Even if your request is granted, we may still use or disclose the restricted information in the case of an emergency. If restricted information is disclosed for your emergency treatment, we will request that the recipient not to further use or disclose it.

Individual Requesting Restriction:

Name: _____ Subscriber ID Number: _____

Address: _____

Telephone: _____ Date of Birth: _____

What PHI do you wish to restrict?

_____

What restriction(s) do you want applied to Blue Shield of California's use or disclosure of the PHI described above?

_____

_____

Signature of Individual or Personal Representative:

_____ Date: _____

If this form is signed by someone other than the individual or the parent of a minor child, such as a personal/legal representative or guardian, you must **submit documentation** showing your right to act for or on behalf of the individual with respect to their healthcare/PHI such as a valid HIPAA authorization, healthcare power of attorney or guardianship papers. **Please also provide the following information:**

Representative's name, address and relationship to the individual for whom this request is being made (print): _____

_____

Note: *If this request is made on behalf of a minor child, the Restriction, if not sooner terminated, will expire upon the child's eighteenth birthday. Other conditions and limitations may apply to Restriction requests submitted on behalf of a minor child.*

Return the completed and signed request to:
Blue Shield of California Privacy Office PO Box 272540, Chico, CA 95927-2540