REQUEST TO RESTRICT THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use this form to ask us to restrict the use and/or disclosure of your protected health information (PHI) in records that we or our business associates maintain in designated record sets.

Member Name:	
Member Address:	
Member Phone Number:	
Member/Health Plan Identification Number:	

Please read the statements in this form and tell us the requested information. You have the right to ask us to restrict the use and/or disclosure of PHI in the designated record set that we or our business associates maintain. We may not agree to your request if we did not create the records, the records are not part of our designated record set, or the law does not give you the right to access the records.

Please tell us which records you want to restrict and whether you want to restrict the use of those records or if you wish to restrict further disclosure of those records:

Please provide the dates of the records you want to restrict:

Please tell us why you want us to restrict the use and/or disclosure of the records:

Please sign and date:

Signature: Date

Personal representative:

If you are not the member, please sign and date below. Check the box that describes your relationship to the member. If you are not the parent or legal guardian, please attach proof of your relationship to the member (e.g., power of attorney, personal representative documentation, etc.).

Print name of personal representative:

Signature of personal representative: Date:

☐ Parent or legal guardian ☐ Power of attorney ☐ Executor ☐ Other:

Please return this form to:

AmeriHealth Caritas VIP Care Plus
Medicare Compliance Department
3875 West Chester Pike
Newtown Square, PA 19073