Purpose: This form is used to request that HealthLink restrict its use or disclosure of Protected Health Information for treatment, payment or health care operations, or to persons involved in the individual's care or payment for that care.

SECTION A: Member for whom the restriction is requested:

Name: _____

Address: _____

Telephone: _____

Date-of-Birth: _____

Gender: _____

Contract/Identification Number (s): _____

Group Identification Number: _____

SECTION B: To the Requestor—please read the following and complete the information requested:

You have the right to request that we restrict our use or disclosure of your Protected Health Information for treatment, payment or health care operations or to persons involved in your care or payment for that care. We are under no obligation to agree to your request. If we do, our agreement must be in writing and we will restrict our use or disclosure of your Protected Health Information as you request. We may, notwithstanding our agreement, use or disclose the restricted information needed for your treatment in an appropriate medical emergency, or when authorized or required by law.

You may end the restriction at any time by notifying us in writing. We may end our agreement to restrict use or disclosure of your Protected Health Information at any time by notifying you in writing. If you agree with our decision to end the restriction, your Protected Health Information will no longer be subject to the restriction. If you disagree, our termination of the restriction will apply only to your Protected Health Information that we create or receive after we gave you our notice terminating the restriction. To exercise your right to request restriction on our use or disclosure of your Protected Health Information, please complete Section B.

Please specify the Protected Health Information you want to restrict:

_____

_____

Please state the restriction you want to apply to that Protected Health Information:

_____

_____

SECTION C – Individual's Signature

I request that you restrict the use or disclosure of my Protected Health Information as specified in Section B above. I understand that you are under no obligation to agree to my request, and that there will be no agreement unless you inform me in writing that you agree to my request.

Signature: _____ Date: _____

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Please complete this form and mail to:

HealthLink
1831 Chestnut Street
St. Louis, Mo. 63103
Attn: HMO Eligibility