Optima Health

# REQUEST FOR RESTRICTION OF USE AND DISCLOSURE

This form is to request a restriction, or limitation, on the protected health information we use or disclose about you for treatment, payment, or health care operations.

Date: ______________________

Member name:___________________________________________________

Member date of birth:___________ Member ID number: ________________

*I understand that Optima Health must disclose health information to conduct its business operations. I can find out about these disclosures in the Sentara Healthcare ACE Notice of Privacy Practices at www.Optimahealth.com. I further understand that Optima Health will consider my request for a restriction but does not have to honor my request.*

The member or the personal representative requests that Optima Health restrict the use or disclosure of protected health information (PHI). The specific information to be restricted is:

______________________________________________________________________

__________________________________________________________

I request that this restriction apply to the following uses and disclosures (who do you want to restrict from getting or using the information?):

______________________________________________________________________

__________________________________________________________

I request that my information may not be accessed, discussed, or restricted, without successful presentation of a password, which I have selected:

The password to be used for all access is:

______________________________________

I understand that if the request is approved, I may terminate this restriction at any time by writing to Optima Health at the address or email below. I further understand that Optima Health will respond to this request in writing and that use and disclosure of the PHI will not be restricted unless I receive approval from Optima Health.

Privacy Statement: Please be aware that email and text communication can be intercepted in transmission or misdirected.

***Mail or email this completed request form to:***

Optima Health
Attn: Compliance Department
PO Box 66189
Virginia Beach, VA 23466
or
shpprivacy@sentara.com

Signature of Requestor ________________________________________________

Printed Name of Requestor _____________________________________________

# REQUEST FOR RESTRICTION OF USE AND DISCLOSURE FORM

*If you are requesting restriction on behalf of someone other than yourself, please enclose proof of your authority to do so (i.e., guardianship order, custody order, court order) as appropriate.*

***Definitions***

**Member:** the person who is subject of the protected health information

**HIPAA Authorized Representative**: someone who has the legal authority to act on an individual's behalf to make decisions about that person's health care. Parents may be HIPAA Authorized Representatives for minors, except those minors who have been given the legal freedom to act on their own. HIPAA Authorized Representatives may include guardians, conservators and other persons who have been given legal responsibility for another individual. Federal law, state law and the specific terms of the appointment determine the authority granted to the HIPAA Authorized Representative.

**Member Identification Number:** the number assigned to an individual by a health plan. Sometimes it is the individual's social security number.

**Password:** This is a combination of letters and/or numbers which is selected by the member and is to be used to identify the person requesting information.