UNITE HERE HEALTH

Restriction Request Form

For Use and Disclosure of Protected Health Information (PHI)

Complete and mail this form to:
Privacy Officer
UNITE HERE HEALTH
P.O. Box 6020,
Aurora, Illinois 60598-0020
(866) 711-4373

Participant Name _____

Participant SS# _____

Requested Restrictions

Patient Information – This is the person for whom Protected Health Information is to be restricted

_____
Patient's Name | Date of Birth (month-day-year) | SS# | Relationship to Participant

_____ ( )
Street | City | State | Zip | Telephone

In completing this form, you are requesting the following restrictions be considered as limitations to UNITE HERE HEALTH's use and disclosure of your health information. If your request is approved, we are bound by the terms of the agreement, until such time as the restriction may be terminated, either by you or UNITE HERE HEALTH. You will be notified in writing of UNITE HERE HEALTH's decision to accept or deny your restriction request. Until a decision is reached, your request for restriction will not be effective.

Do not release information regarding:

- ❑ Any medical diagnosis/treatment
- ❑ A specific diagnosis – state diagnosis here: _____
- ❑ Treatment between these dates: _____ and _____
- ❑ Other – explain: _____

_____

_____

Do not release information to:

- ❑ Name of the person you do not want to have access: _____
  Relationship: _____
- ❑ Anyone other than myself

Reason request is being made: _____

_____

_____

_____
Signature of Patient (parent or guardian if the patient is a minor) or Personal Representative | Date

_____ ( )
Printed Name | Phone Number Where We May Contact You

_____
Relationship to Patient

For UNITE HERE HEALTH Use Only

❑ Accepted ❑ Denied

Privacy Officer Signature: _____ Date: _____

Dept. Manager Signature: _____ Date: _____