THE OHIO STATE UNIVERSITY
HEALTH PLAN

Member Request to Restrict Uses and Disclosures of Personal Health Information (PHI)

Member Information

Name_____

Date of Birth_____/_____/_____ Address _____

City_____ State and Zip_____

Phone_____ E-mail Address_____

OSU Employee/Subscriber Information

Name_____

Employee ID_____

Requestor Information (complete if you are not the member)

Name _____

Address_____ City_____

State & Zip_____ Phone_____

Relationship to Member_____

THIS SECTION MUST BE COMPLETED

I hereby request that the following restriction(s) be placed on the uses and disclosures of my personal health information by the Ohio State University Health Plan Inc.

Benefits affected: _____ Medical _____Vision _____ Flexible Spending Account _____ Dental

List of Restrictions Requested

Please give a full, specific description of the type of restrictions you are requesting regarding how and to whom your personal health information is used and disclosed. Restrictions may only be requested for those uses and disclosures that relate to your treatment, your payment or insurance, or the business operations of The Ohio State University Health Plan Inc. (For example, you may request that we restrict the use of your information for disease management purposes.)

I understand that The Ohio State University Health Plan Inc. is not required to agree to my restriction requests, but that OSU Health Plan may only be required to attempt to accommodate reasonable requests when appropriate. I further understand that OSU Health Plan reserves the right to terminate an agreed-to restriction if it feels that termination is appropriate, and that I also have the right to terminate, in writing, any restriction by sending a termination notice to the Privacy Officer at the address at the bottom of this form.

Signature **Date**

Print Name

Return this form to the HIPAA Privacy Officer, OSU Health Plan, Inc., 700 Ackerman Road, Suite 440, Columbus, Ohio 43202 or fax to (614) 292-2667.