



**Member Request to Restrict Uses
and Disclosures of Protected Health Information**

Section I: Member/Dependent Information -All fields are mandatory and should be completed in order for the form to be processed timely. Please Print Clearly & Legibly

Name _____

Date of Birth ____/____/____ Address _____

City _____ State and Zip _____

Phone _____ E-mail Address _____

Section II: OSU Employee/Subscriber Information

Name _____

Trustmark Member ID Number _____

Section III: Requestor Information (complete if you are not the member)

Name _____

Address _____ City _____

State & Zip _____ Phone _____

Relationship to Member _____

Section IV: THIS SECTION MUST BE COMPLETED

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

Benefits affected: Medical Claim (Trustmark) Flexible Spending Account

List of Restrictions Requested

Please give a full, specific description of the type of restrictions you are requesting regarding how and to whom your protected 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.)

This form must be accompanied by signature page on the second page of this form.



THE OHIO STATE UNIVERSITY

HEALTH PLAN

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 Health Plan Privacy Officer at the address at the bottom of this form.

Signature (Digital/electronic signature is not accepted)

Date

Print Name

For this form to be valid, it must be filled out accurately and completely.

Return this form to the HIPAA Privacy Officer, OSU Health Plan, Inc., 700 Ackerman Road, Suite 1007, Columbus, Ohio 43202 or fax to (614) 292-8366.

FOR OSU HEALTH PLAN PRIVACY OFFICE USE:

APPROVED BY: _____
OSU Health Plan HIPAA Privacy Officer

DATE: _____

REASON DENIED: _____

DENIED BY: _____
OSU Health Plan HIPAA Privacy Officer

DATE: _____