THE OHIO STATE UNIVERSITY
HEALTH PLAN

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/Member 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.

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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.

____ ______________________________
Member Signature or Personal Representative Signature **Date**

____
Print Name

If Personal Representative, source/document, such as Healthcare Power of Attorney, of authority to act for Member is required.

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:____ **DATE:**________________________
OSU Health Plan HIPAA Privacy Officer

REASON DENIED: ____

DENIED BY:____ **DATE:**________________________
OSU Health Plan HIPAA Privacy Officer