ProCare Rx

Request for Restriction of Protected Health Information (PHI)

WHY THIS FORM?

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have a right to request a restriction on the use and/or disclosure of your PHI in the Designated Record Set (DRS) that is maintained by EHIM, Powered by ProCare Rx, or its Business Associate (BA). Please complete this form in its entirety so that we may provide you with the correct information you are requesting.

A. Member Information

Last Name:	First Name:	Middle Name:	
Date of Birth:	EHIM Member #:	Phone #:	
Address:	City:	State:	Zip:

B. Restriction Information

1. **Availability of Restriction.** The request will be mailed to Member, unless specified below:

☐ I hereby request that EHIM, Powered by ProCare Rx, mail this restriction to the following individual(s) and/or entit(ies) and address(es):

Name:	Address:
Name:	Address

2. **Description of PHI Records.** The following is a description of the records that I wish to have amended (i.e., all PHI or PHI related to a specific date, illness, or treatment):

3. **The Method of Restriction.** My records stated above should be restricted in the following manner (i.e., do not disclose information about my claims to my spouse; send my PHI to the following location, email address or fax number; communicate PHI when a password is provided; do not disclose/send my PHI to the following location, email address or fax number; communicate PHI when a password is provided; do not disclose/send appointment reminders to a certain address; do not allow my family members covered under my plan to access my PHI, etc.):

4. **Applicability.** This restriction applies to the following individual(s) (i.e., my spouse, all family members, those individuals covered under my plan, etc.):

5. **Reason for Restriction.** The following is the reason I want my PHI to be restricted (i.e., expenses were paid out of pocket, life is endangered):

6. **Alternative Method of Communication.** If the method of communication I request is not feasible, EHIM, Powered by ProCare Rx, may deny my request. The following is alternative contact information

Name:	Fax Number:
Address:	Email Address:

7. **Expiration of Request.** This request will expire when I am no longer an eligible member of my current health coverage, unless I specify the following:

☐ Date: _____ OR ☐ After specific event (i.e. surgery, end of pregnancy, etc.) _____

8. **Revocation/Cancellation of Restriction**. I understand that either party may revoke this request and/or cancel the restriction at any time by notifying the other party in writing. I understand and acknowledge that revocations/cancellations of this request/restriction shall not apply to information that has already been released or affect actions taken by EHIM, Powered by ProCare Rx, prior to the revocation/cancellation.

9. **Denial of Request.** I understand and acknowledge that **EHIM, Powered by ProCare Rx, IS UNDER NO OBLIGATION TO AGREE TO THIS REQUEST FOR RESTRICTION OF MY PHI**, except, however, EHIM, Powered by ProCare Rx, shall agree to a restriction to a health plan if (1) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (2) the PHI pertains solely to a health care item and/or service for which I, or individual other than the health plan on behalf of me, have paid for in full. I further understand and acknowledge **MY REQUEST FOR A RESTRICTION MAY BE DECLINED IF**: (1) the request is not reasonable; (2) the information I provide is not accurate; (3) this form is not completed in its entirety; and/or (4) I do not sign below. If EHIM, Powered by ProCare Rx, denies this request, it will provide me with a written explanation of the reason(s) and whether I have a right to further review.

10. **Rights and Acknowledgement.** With certain exceptions, I have the right to request that EHIM, Powered by ProCare Rx, place restrictions on its use and/or disclosure of my PHI for treatment, payment or health care operations (TPO), or disclosure to individuals involved in my care or payment for my care (i.e., family member, relative, friend, etc.). By signing below, I hereby authorize my information be restricted as described on this form. If EHIM, Powered by ProCare Rx, accepts this request, it will abide by the restriction from the date upon which EHIM, Powered by ProCare Rx, approves the request, except as required for emergency treatment and/or permitted by law. I understand and acknowledge this request shall not apply to information that has already been released or affect actions taken by EHIM, Powered by ProCare Rx, prior to this request. I further understand and acknowledge that EHIM, Powered by ProCare Rx, is not responsible for any action taken by any authorized recipient and/or discloser of the information released pursuant to any signed authorization to use/disclose my PHI. The information described on this form is protected by law and shall only be restricted as indicated above unless otherwise required and/or permitted by law.

Signature:	Date:

If you are signing as a personal representative, complete the section below. A parent/legal guardian must sign below for a minor under the age of eighteen (18). You may be required to provide additional documentation to show that you have a legal right to request the information, unless you have completed a Designation of Personal Representative signed by the Member naming you as a personal representative. Examples of these documents include Letters of Representation or Guardianship Papers.

Signature of Personal Representative: Print Name:	Date:

Relationship: ☐ Parent/Legal Guardian ☐ Personal Representative ☐ Other

C. TO BE COMPLETED BY EHIM

Request Approved. Effective Date:

Request Denied. Reason:

Additional Comments:

EHIM Representative Signature	Date:

If you have any questions, please contact the EHIM Privacy Officer at (800) 311-3446. Please either fax this form to (248) 948-9904 or mail to:

EHIM, Powered by ProCare Rx
ATTN: Privacy Officer
26711 Northwestern Hwy, Suite 500
Southfield, MI 48033