# REQUEST FOR RESTRICTION ON USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Date of Request:_____

Member Name: _____ Date of Birth:_____

Member CIN: _____ Telephone Number:_____

I understand that CalOptima Health may use or disclose (release) my Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. CalOptima Health may also release information to someone involved in my care or the payment for my care, such as a family member or friend.

I understand that CalOptima Health does not have to agree to my request.

I request a restriction on CalOptima Health's Use and Disclosure of Protected Health Information (PHI). The information I want limited is:

_____

_____

I want to limit CalOptima Health's:

- ☐ Use of this Information
- ☐ Disclosure of this information
- ☐ Both the use and disclosure of this information

I want the limits to apply to the following person/entity (For example: spouse): _____

## REQUIRED USES AND DISCLOSURES

Even if CalOptima Health agrees to the restriction, the information may still be shared under the following circumstances:

- During medical emergency if the restricted information is needed to provide emergency treatment. However, if the information is disclosed during an emergency, CalOptima Health will tell the recipient not to use or disclose it for any other purpose.
- For health agency oversight activities
- For uses or disclosures otherwise required by law
- If a restriction is agreed to, the termination in writing
- I orally agree to the termination and the oral agreement is documented
- CalOptima Health informs me that it is terminating the agreement. In this case, the termination is only effective for PHI created or received by CalOptima Health after I am notified of the termination.

## YOUR RIGHTS:

For more information about your privacy rights, please refer to your copy of the CalOptima Health Notice of Privacy Practices. A copy can be found on our website: www.caloptima.org, or from CalOptima Health's Customer Service Department by calling **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8:00 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TTY at 711. We have staff who can speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima Health or with the secretary of the Department of Health and Human Services. To file a complaint with CalOptima Health, contact CalOptima Health Customer Service Department at **1-714-246-8500** or write to:

**ATTN Customer Service Department**
**CalOptima Health**
505 City Parkway West
Orange CA 92868

CalOptima Health cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of the privacy rights in this Notice.

## SIGNATURE:

Member Signature: _____

If Authorized Representative (please include legal documentation):

Print Name: _____ Relationship to Member: _____