Providence
Medicare Advantage Plans

Information about Your Request to Restrict
Protected Health Information (PHI)

What does the right to restrict PHI mean?

You or your personal representative have the right to request a restriction of the uses and disclosures of your protected health information (PHI). Member or personal representative is only allowed to request a restriction of the use and disclosure pertaining to treatment, payment, or health care operations in accordance with the Health Insurance Portability and Accountability Act. Any other uses or disclosures that are required by law cannot be altered by the health plan. Providence Medicare Advantage Plans understands the importance of keeping your health information confidential. We use and share only information that is necessary to provide services to our members and as permitted and required by law.

What do I need to understand to use this right?

- Providence Medicare Advantage Plans will consider all requests for restrictions carefully; however, Providence Medicare Advantage Plans is not required to agree to a requested restriction. Any restriction PHA accepts will be limited to the information under our control.
- Providence Medicare Advantage Plans will try to accommodate all reasonable requests for a restriction, but reserves the right to deny a request if it would be infeasible to implement the restriction.
- Providence Medicare Advantage Plans is not able to accept a request if it is made after the date of service occurred and information has already been released.
- If the request is granted, you will be notified in writing.
- If the request is granted it will be processed within seven (7) days of receipt of the request.
- The request for restriction may be denied and if so, you will be notified in writing of such denial.
- In situations where the member who requested the restriction is in need of emergency treatment, Providence Medicare Advantage Plans may use professional judgment. If the member would benefit from overriding the restriction request due to an emergency, Providence Medicare Advantage Plans will release the minimum necessary PHI to assist the provider in providing emergency treatment.
- A member may revoke this restriction in writing at any time by mailing or faxing the request to Customer Service at the address listed below.

How do I restrict my PHI?

Enclosed is the Member Request to Restrict Protected Health Information (PHI) you requested. Please complete the entire form, sign it and return it to Providence Medicare Advantage Plans. You may send your Member Request to Access to Providence Medicare Advantage Plans at:

Providence Medicare Advantage Plans
Attn: Customer Service
PO Box 5548
Portland Oregon 97228-5548

You may fax your Member Request to Access form to 503-574-8608 or you may hand deliver it (if mailing, use only the post office box address listed above) to the following address:

Providence Medicare Advantage Plans
3601 SW Murray Blvd. #10
Beaverton Oregon 97005-2359

If you have any other questions or concerns, you may contact the Providence Medicare Advantage Plans Customer Service Team at 503-574-8000 or 1-800-603-2340. If you are hearing impaired and use a Teletype (TTY) Device, please call our TTY line at 711. Customer Service assistance is available to answer questions, seven days a week, between 8 a.m. and 8 p.m. (Pacific Time).

Thank you,

Providence Medicare Advantage Plans

Enclosure

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Member Request to Restrict Protected Health Information (PHI)

Use this form to request a restriction on the disclosure of Protected Health Information (PHI) in the Designated Record Set that Providence Health Plan (PHP) or one of its Business Associates maintains. If you need assistance completing the form, please contact the Providence Medicare Advantage Plans Customer Service number listed on your member identification card. You must complete all the fields on this form.

MEMBER INFORMATION		
Member Last Name	**Member First Name**	**Middle Initial**
Member Date of Birth	**Member Identification Number (See your member ID card)**	**Group Number (See your member ID card)**
Member Street Address	**City and State**	**ZIP Code**

This request is (check one):

❑ New

❑ TO REVOKE an existing restriction effective (indicate MM/DD/YY)_____Skip to signature line

Restriction Requested

❑ Restriction on use or disclosure relating to treatment, payment and/or healthcare operations.
Please provide details

_____

❑ Restriction on use and disclosure of PHI: (check all that apply)

❑ To a family member, other relative, or other identified person, directly relevant to their involvementwith my care or payment for health care services. Provide details (e.g., restricted information and/or
name of family member, friend)

_____

❑ Relating to my location, my general condition or my death to a family member, a personal representative or other person responsible for my care. Provide details (e.g., restricted information and/or name of family member, friend)

_____

Please note that, by law, we may be required to make the following types of disclosures, and so any restriction we agree to will not affect disclosures in the following circumstances or other circumstances where disclosures are required by law:

- Uses and disclosures for which an authorization or opportunity to agree or object is not required; such as in the cases of national security, public health activities, law enforcement, victims of abuse, neglect or domestic violence, research or other disclosures required by law;
- Disclosures required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with HIPAA.

MEMBER SIGNATURE AND DATE

By:_____ **Date:**_____

(Member Signature)

- OR –

By:_____ **Date:**_____

(Member's Designated Legal Representative/Guardian Signature)

Relationship to member: ☐ Parent ☐ Legal guardian* ☐ Holder of Power of Attorney*

***If this form is signed by someone other than the member or Parent, please attach legal documentation if you are the legal guardian or Holder of Power of Attorney.**

- ***Note: To parents/legal guardians of minors: state laws may prohibit Providence Health Assurance from acting on your request about Sensitive Information without written authorization from the minor member. (Both parent and minor must sign.)***

Providence
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Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-603-2340 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-603-2340 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-603-2340 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-603-2340 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-603-2340 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-603-2340 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-603-2340 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-603-2340 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-603-2340 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-603-2340 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-603-2340 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-603-2340 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-603-2340 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-603-2340 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-603-2340 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-603-2340 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-603-2340 (TTY: 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。