HARRISON TRUST

A Family Health Plan

www.harrison.aibpa.com

REQUEST FOR RESTRICTIONS ON USE AND/OR DISCLOSURE OF PHI

This form can be used for requesting restriction(s) of use and/or disclosure of your Protected Health Information (PHI). Please complete the information below and then return a copy to our office at:

Client Services
Harrison Trust
1220 S.W. Morrison St., Suite 300
Portland, OR 97205

Once we receive a completed copy of this letter, we will make a determination about our ability to accommodate your request and we will notify you of this decision.

Please contact us at (503) 224-0048 ext. 1679 or 800-547-4457 ext 1679 if you have any questions.

Complete this background information if the request is for your own health information.

Participant Name:____ Birth Date: _______________

Social Security Number: __________________________

Plan Member ID Number (if different than your Social Security Number): ___________________

Name of Group Health Plan: ____

Your Address: ____

____

Your Telephone Number: _______________________________

Your Email Address (if any): ____________________________

____ _____/_____/_____

Signature Date

Relationship to Employee: ☐ Self ☐ Dependent

If you are covered as a dependent, please provide the employee information below:

Employee Name: ____

Employee Plan ID Number or Social Security Number: ___________________________________

Complete this background information if the request is being made on behalf of a dependent minor.

Your Name:____ Birth Date: _________________

Your relationship to the dependent minor: ____

Your Social Security Number: ____________________________________

Dependent Minor's Social Security Number: ___________________________________

Or Plan Member ID Number (if different than Social Security Number):_______________________

Name of Group Health Plan: ____

Your Relationship to Employee: ☐ Self ☐ Spouse ☐ Other:_________________

If you are not the covered employee, please provide the employee information below:

Employee Name: ____

Employee Plan ID Number or Social Security Number: ________________________________

____ _____/_____/_____

Signature of Parent Date

If this request is being made by a Personal Representative of the plan participant, please complete the above information about the plan participant and also provide the following information:

Name of personal representative: ____

Relationship to participant or nature of authority: ______________________________________

____ _____/_____/_____

Signature of Personal Representative Date

Please Complete the Following

I, ________________________, am requesting a restriction on the Health Plan's use and/or disclosure of my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) in the manner described below. I understand that the Health Plan may deny this request for any reason. I also understand that if agreed to, the Health Plan may not be able to honor this request if I require emergency treatment and that the Health Plan may remove this restriction in the future, if I am notified in advance.

Description of Restriction of the Health Information to be Used or Disclosed. The following is a description of the specific health information I wish to restrict (attach additional paper if needed):

____

Persons/Organizations Restricted from Use and/or Disclosure of Health Information. I request that the following person(s) and/or organization(s) not be allowed to use, receive and/or disclose the health information described above.

____

By signing this form, I am confirming that it accurately reflects my wishes.

____ _____/_____/_____

Signature Date