Request for Restrictions on Use & Disclosure of Protected Health Information (PHI)

Complete the following chart with information about the person whose PHI is subject to this request.

Name (Last, First, MI):	
Address (City,State,Zip):	
Phone:	
Date of Birth:	

If you are not the employee, complete the following:

Employee Name:	
Employee ID #:	
Employee Date of Birth:	

I am requesting that use and disclosure of my PHI be restricted as detailed below:

What information do you want to be restricted?

Do you want to limit the Plan's use of that information, its disclosure of that information or both?

To whom do you want the limits to apply?

If I am a personal representative, I certify and attest that I am the duly authorized representative of the person whose health information is subject to this request. *(A personal representative may be requested to provide verification of representative status.)*

_____ _____

Signature of applicant or personal representative **Date**

Relationship of personal representative to member: _____

Send completed form to:

Privacy Official
Human Resources
7575 E. Main Street
Scottsdale, AZ 85251

Phone: (480) 312-7600
FAX: (480) 312-7960

FOR HUMAN RESOURCES USE ONLY

Request approved ☐

Date information will be provided: _____

Request denied ☐ Reason for denial_____

By: _____ _____ _____

COS Signature Date Name and Title