

NORTHWESTERN HEALTH SCIENCES UNIVERSITY HEALTH PLAN REQUEST TO RESTRICT CERTAIN USES AND DISCLOSURES

You have a right to request that NWHSU's Health Plan(s) restrict:

- Uses or disclosures of your protected health information ("PHI") in carrying out payment or health care operations activities.
- Disclosures to family members or friends involved in your health care or payment relating to your health care.

Use this form to request such a restriction. **THE HEALTH PLAN IS NOT REQUIRED TO COMPLY WITH YOUR RESTRICTION REQUEST.**

IMPORTANT: IF YOU BELIEVE YOU WILL BE ENDANGERED IF YOUR PHI IS DISCLOSED THROUGH A COMMUNICATION WE MIGHT MAKE TO YOU OR SOMEONE IN YOUR HOUSEHOLD, PLEASE SUBMIT THE FORM ENTITLED "REQUEST FOR CONFIDENTIAL COMMUNICATION."

Please submit this form to: **Northwestern Health Sciences University
Deborah Hogenson, Health Plan Privacy Officer
Attn. Human Resources
2501 W. 84th St.
Bloomington, MN 55431**

Your name: _____

Address: _____

Daytime phone number: _____

Please select one :

___ I participate in or am covered under the following Health Plan:

___ Medical

___ Dental

___ Section 125 Medical Reimbursement

___ I am the personal representative of an individual participating in or covered under the following Health Plan (*please attach completed Designation of Personal Representative form*).

___ Medical

___ Dental

___ Section 125 Medical Reimbursement

____ I request the Health Plan to restrict its uses or disclosures of my PHI for purposes of payment or health care operations. Specifically, I request the following restrictions (describe):

(If more space needed, please attach separate sheet)

____ I request the Health Plan to not make disclosures to the following family members or friends who may be involved in my health care or payment with respect to my health care (list names):

(If more space needed, please attach separate sheet)

Please Read Carefully and Sign

I understand that the Health Plan is not required to agree to my requested restriction. I also understand that if the Health Plan agrees to the requested restriction, it may stop doing so prospectively so long as it informs me that the restriction is removed.

Signature

Date

For office use only:

Received by: _____ Date: _____