REQUEST NOT TO USE OR DISCLOSE HEALTH INFORMATION

I understand that the Clackamas County group health plan may use and disclose protected health information about me for the purposes of health care treatment, payment and health care operations without my consent. Request to restrict use and disclosure of protected health information concerning health care treatment, payment or health care operations about me by the Clackamas County group health plan in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that the group health plan is not required to agree to this restriction.

I understand that if the group health plan agrees to this restriction, either the plan or I may terminate this restriction at any time. The termination of the restriction is only effective for future uses and disclosures.

I understand that this restriction is void if protected health information must be used or disclosed to provide emergency treatment for me.

I request that the following protected health information be restricted (description of information):

_____

_____

_____

I request that the use and disclosure of the above-described information be restricted in the following manner (description of restriction):

_____

_____

_____

I request that the above described health information not be disclosed to the following individuals or entities (list individuals or entities to which information would not be disclosed):

_____

_____

_____

I understand that if a restriction is not specifically listed above and agreed to in writing by the group health plan, it will not be effective.

Signature/Date: _____

Name (please print): _____

Daytime Telephone Number(s): _____

RESPONSE TO REQUEST TO NOT TO USE OR DISCLOSE HEALTH INFORMATION

- ❑ Request granted. The plan will make the appropriate amendment to the designated records set.
- ❑ Request denied for the following reason:

_____

_____

_____

_____

_____