REQUEST FOR RESTRICTION

hmsa
An Independent Licensee of the Blue Cross and Blue Shield Association

ALL SECTIONS MUST BE COMPLETED UNLESS OTHERWISE SPECIFIED

PART A: INFORMATION OF MEMBER REQUESTING RESTRICTION

Last Name	First Name		MI
Address	City	State	ZIP Code
Email	Home Phone # ( )	Cell Phone # ( )	
HMSA Subscriber Number(s) (Located on your membership card)		Birth Date _ _ /_ _ /_ _ _ _	

PART B: RESTRICTION INSTRUCTIONS

1. Please choose the member information you would like HMSA to restrict in use and/or release by checking the appropriate box below: (check all that apply)

☐ Claims & Payment	☐ Eligibility & Enrollment	☐ Dues Payment & Billing
☐ Referral & Preauthorization	☐ Medical Records	☐ Sexually Transmitted Disease
☐ HIV/AIDS	☐ Appeals	☐ Abortion/Family Planning
☐ Alcohol/Substance Abuse	☐ All	☐ Other: _____

2. Please describe the restriction you want applied to the information stated above.

PART C: EXPIRATION

This restriction will expire five years from the date it was signed or as specified below: (choose only one)

☐ One year ☐ Until: _ _ /_ _ /_ _ _ _ (must be less than five years)

☐ Three years ☐ Event described here: _____ (must occur within five years)

PART D: YOUR INDIVIDUAL RIGHTS

I understand that (**please read**):

- I have the right to request that HMSA restrict its use or release of my protected health information for treatment, payment, health care operations, or to persons involved in my care or payment for that care. HMSA is under no obligation to agree to my request. If HMSA does agree, it will confirm such agreement in writing. HMSA may, notwithstanding an agreement, use or release the restricted information needed for my treatment in an appropriate medical emergency or when the use or disclosure without my written permission is allowed or requested by law.
- I may end the restriction at any time by giving HMSA five business days written notice to the address indicated below.
- Upon request, I am entitled to receive a copy of this request.

(Continued on next page)

PART E: SIGNATURE

I, (print your name) _____ have had full opportunity to read and understand the contents of this form. I request that HMSA restrict the use and/or release of my confidential member information as specified in part B of this form. I understand HMSA is under no obligation to agree to my request and that there will be no restriction unless HMSA informs me in writing of such agreement.

Signature: _____ **Date:** _ _ /_ _ /_ _ _ _
(Member or Authorized Representative)

If signed by other than the member or parent of minor child, please print your name below and indicate your relationship. Provide a copy of verification of your legal right (e.g., power of attorney documentation) to make this authorization.

Authorized Representative Name: _____

Relationship to Member: _____

INCOMPLETE FORMS WILL NOT BE PROCESSED
ALL FIELDS ARE REQUIRED UNLESS OTHERWISE SPECIFIED

Please complete, sign, and submit this form to:
HMSA Privacy Office, P.O. Box 860, Honolulu, HI 96808-0860, (fax) 952-7580

(00) 0135-5660 6:16 LE