



RESTRICTION REQUEST

Purpose: This form is for use by the TRICARE beneficiary or the beneficiary's authorized representative to request the placement of a restriction on the use or disclosure of the beneficiary's protected health information for treatment, payment or health care operations, or to specified persons involved with the individual's care or payment for care.

Section A: Individual Requesting Restriction

Name:							
Address:							
Telephone:				E-mail:			
Social Security Numbers	Sponsor:				Beneficiary:		

TO THE BENEFICIARY: Please read the following and complete the information requested.

You have the right to request that TriWest restrict our use of your protected health information (PHI) for treatment, payment or health care operations or disclosure to persons involved in your care or payment for your care. We are under no obligation to agree to your request. If we do, our agreement must be in writing. We will then restrict our use or disclosure of your PHI as you request. We may, notwithstanding our agreement, use or disclose the restricted information when needed to treat you in a medical emergency or when required or authorized by law.

Either you or TriWest may end a restriction agreement at any time by notifying the other in writing. If you agree with our decision to end a restriction agreement, your PHI will no longer be subject to the restriction. If you disagree, our termination of the restriction agreement will apply only to your PHI that we create or receive after we gave you our notice terminating the restriction agreement. To exercise your right to request restriction on our use or disclosure of your PHI, please complete Section B.

Section B: Restriction Requested

Please specify the PHI, the use or disclosure of which you want to restrict.

Please state the restriction you want to apply to that PHI.

Beneficiary Signature: _____

Date: _____

If this request is by a personal representative on behalf of the beneficiary, complete the following:

Personal Representative's Name: _____

Relationship to Beneficiary: _____

YOU ARE ENTITLED TO A COPY OF THIS REQUEST

Please submit the completed and signed request to: TriWest Healthcare Alliance; Attn: HIPAA Privacy Official; P.O. Box 42049; Phoenix, AZ 85080-2049

TriWest HIPAA Form 80102A

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