



**HIPAA RESTRICTION REQUEST**

**Purpose:** This form is for use by beneficiaries or their authorized representative to request that a restriction be placed on the Use and Disclosure of the beneficiary's PHI.

**SECTION A: Individual Requesting Restriction**

Name:			
Address:			
Telephone:	(    )	E-mail:	
Social Security Number:	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'S 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