Community HealthFirst™
Medicare Advantage Plans

Information About Your Request to Restrict Disclosures of Your Protected Health Information (PHI)

What does the right to restrict disclosures of PHI mean?

You may ask us not to share your information for treatment, payment, or health care operations. You also have the right to ask us not to share your information with family, friends, or other persons involved in your health care.

What do I need to understand to use this right?

If you ask us to restrict how we share your health information with others, it is okay to change your mind later. You must tell us that you have changed your mind by calling our customer service department so we know to change how we share your information.

If we agree to your request, we will follow your wishes, unless you have a medical emergency and we believe we need to share your information to help you get better. However, we are allowed to deny your request.

Community Health Plan of Washington will respond to this request within 30 days. If we can't respond within 30 days, we will send you a written notice that it will take longer.

How much will this cost me?

There is no fee to restrict disclosures of your health information.

How do I make a request?

Complete and print the attached form, then mail it to the address printed at the end of the form.

How will I know if my request is processed?

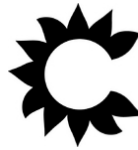
We will send a letter to the address you write on the form. The letter will tell you if we approved or denied your request.

How can I get a full notice of my privacy rights?

A full notice of your privacy rights is posted to the Community HealthFirst web site at: Member rights and privacy page.

You may also request a copy by calling the Community Health Plan of Washington's Customer Service department at 1-800-942-0247, 7 days a week, from 8am to 8pm. If you are hearing or speech impaired, please call TTY 7-1-1 (toll free).

REQUEST TO RESTRICT DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)



COMMUNITY HEALTH PLAN of Washington™

Section A: Member Information

Member Name: ______________________________ Date of Birth: ____________________

Member ID #: ______________________________ Date of Request: ____________________

Address: ____

City: ______________________________ State: ______ ZIP code: ______________

Phone: ______________________________ Fax: ______________________________

Choose One:

☐ OK to leave message with detailed information ☐ Leave message with call back number only

Section B: Details of the Request

Please describe the information you wish to restrict. Provide as much detail as possible about what information you want restricted and how.

Section C: Persons Restricted

Please list the persons or businesses to be restricted from the above information.

Section D: Reason for the Restriction

Describe why you want the restriction on your protected health information.

Section E: Signature and Date

Member or Representative Name: ______________________________

Member or Representative Signature: ______________________ Date Signed: ____________

Please complete the form and return a copy to:

Community Health Plan of Washington
Attention: Compliance, Privacy and Security Officer
1111 Third Avenue, Suite 400
Seattle, WA 98101
Fax: (206) 521-8834
Email: compliance.officer@chpw.org

Please type or print neatly. We will not process incomplete or illegible forms.