



Community Health Plan of Washington Request for Restriction(s) on the Use and Disclosure of Protected Health Information

I understand that I have the right to request restriction(s) as to how my protected health information (PHI) may be used and/or disclosed to carry out treatment, payment, or health care operations, or disclosed to family members and others involved in my care. I understand that Community Health Plan of Washington (CHPW) may not be required to agree to the restriction(s) requested. Even if my request for restriction(s) is denied, I will generally have the opportunity to agree or object prior to disclosures to persons involved in my care. If CHPW agrees to a requested restriction, it will be binding except in the case of emergency treatment. If restricted information is released for my emergency treatment, CHPW will request the provider not to further use and/or disclose that information.

1. **Member Name:** _____ **Date of Birth:** _____

Member ID Number: _____ **Date of Request:** _____

Member Address: _____

Member email: _____

Member Phone: _____ **Member Fax:** _____

Choose one: Ok to leave message with detailed information.

Leave message with call-back number only.

2. I request the following restriction(s) on the use and/or disclosure of my PHI.



COMMUNITY HEALTH PLAN
of Washington™

The power of community

The notice is also available online at:
<https://www.chpw.org/for-members/your-privacy-and-rights/>

The notice is also available online at:
<https://medicare.chpw.org/member-center/member-rights/>