Request for Restriction on Uses/Disclosures of PHI

As a member of The Health Plan of West Virginia, Inc., you have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment, or health care operations.

Member Name:		
Address:		
City:	State:	Zip Code:
Date of Birth:	Plan ID Number:	
Phone Number:	Email Address:	
Member Signature:		Date:
Legal Representative Signature: *(if applicable)*		Date:
Relationship to Member:		

I am requesting a restriction on the use and/or disclosure of my protected health information as described below. I understand that The Health Plan may deny this request. If the request is approved, I understand the restriction will not apply in the case of an emergency.

Description of health information to be restricted:	
Dates of health information to be restricted:	
Persons/organizations restricted from use/disclosure:	

The Health Plan will review this request and let you know of our decision in writing.

Submit this form to The Health Plan of West Virginia, 1110 Main Street, Wheeling WV 26003 Attn: Compliance Department or email to HIPAA@healthplan.org. We will notify you in writing of our decision.

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