Individual Request Not to Use or Disclose Health Information

THIS FORM WILL ALLOW ME, AS A CITY OF HOUSTON SELF-INSURED MEDICAL GROUP HEALTH PLANS CUSTOMER, TO REQUEST A RESTRICTION ON THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION (PHI). I UNDERSTAND THAT THE CITY OF HOUSTON SELF-INSURED MEDICAL GROUP HEALTH PLANS WILL CONSIDER ALL REQUESTS FOR RESTRICTIONS CAREFULLY. HOWEVER, THE CITY OF HOUSTON SELF-INSURED MEDICAL GROUP HEALTH PLANS ARE NOT REQUIRED TO AGREE TO A REQUESTED RESTRICTION.

Note: If your request for restrictions is granted, it will affect only written and oral communications by the Plans. If you also wish your physician or anyone outside of the City of Houston self-insured health plans to make this change, you must obtain their agreement separately.

VERIFICATION – (Please Print)

Identification of Customer: (The following information is needed for verification. Please complete all applicable items).

Name of Customer: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone No.: _____ Employee ID No.: _____

Group or Account No. on ID Card: _____

Subscriber Name (if different from Customer): _____

Subscriber Relationship to Customer: _____

I understand that the City of Houston self-insured medical group health plans may use and disclose protected health information about me for purposes of health care treatment, payment, and health care operations without my consent. I request to restrict use and disclosure of protected health information concerning health care treatment, payment or health care operations about me by the City of Houston self-insured medical group health plans in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Group Health Plan Not Required To Agree

I understand that the group health plan is not required to agree to this restriction.

Termination of Restriction

I understand that if the group health plan agrees to this restriction, either the Plan or I may terminate this restriction at any time. The termination of the restriction is only effective for future uses and disclosures.

Emergency Treatment Exception

I understand that if protected health information must be used or disclosed to provide emergency treatment for me, then this restriction is void.

Questionnaire

Requestor: Please complete all of the following questions. If the question is not applicable, mark N/A on the answer line.

(1) I request the following information be restricted [description of information]:

_____

_____

(2) I request that use and disclosure of the above described information be restricted in the following manner [description of restriction]:

_____

_____

(3) I request that my protected health information not be disclosed to the following individuals or entities [list individuals or entities to which information would not be disclosed]:

_____

_____

I understand that if a restriction is not specifically listed above and agreed to in writing by the group health plan, it will not be effective.

Signature: _____ Date: _____

Please Return This Completed Form To:
Privacy Officer,
City of Houston Self-Insured Medical Group Health Plans
Human Resources Department
611 Walker, 4th Floor, Houston, Texas 77002
Email: PrivacyOfficer@houstontx.gov; FAX: 832.393.7208.