# Restriction on Use & Disclosure of Protected Health Information

**Name:**_____ **Date:**_____

## I. Request for Restriction

I understand that the Scott County Health Plans (the "Plan") may use and disclose Protected Health Information (PHI) about me for purposes of health care treatment, payment and operations without my authorization or opportunity to agree or object. I ask that disclosure and use of my PHI concerning treatment, payment and health care operations be restricted. I ask that use and disclosure of my PHI to family members, relatives, friends or other persons involved in my care, or payment for that care be restricted in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended.

a. I request that the following information be restricted:

_____

_____

b. I request that the use and disclosure of the information described in (a) be restricted in the following manner:

_____

_____

c. I request that my PHI not be disclosed to the following individuals or entities:

_____

_____

I understand that the Plan is not required to agree to this restriction.

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## II. Other Important Information

I understand that if the Plan agrees to this restriction, either they or I may terminate this restriction at any time. If the Plan informs me that it is terminating its agreement to a restriction, the termination of the restriction only affects PHI created or received after Scott County informs me of the termination.

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

I understand if the Office of Civil Rights investigates the Plan compliance with the Privacy standards, uses or disclosures required by law, this restriction is not effective.

I understand that if a restriction is not specifically listed above and agreed to in writing by the Plan, the restriction is not effective.

## III. Signature of Individual or Individual's Representative

_____ _____
Signature of Plan Participant or Legal Representative Date

If signed by a legal representative, relationship to Plan participant:_____

_____ _____
Signature of Witness Date