CareConnect
Healthier Insurance™

REQUEST RESTRICTIONS OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Purpose: This Form is intended for use by an individual to exercise his/her right to request that CareConnect Insurance Company, Inc. ("CareConnect") restrict use or disclosure of protected health information.

SECTION A: Member requesting. (Please Print)

Member's Name: _____

Address: _____

Member Identification Number: _____ Date of Birth: _____

Group or Account # on ID card: _____

Phone number where we can reach you to process your request (required): (___) ___ - _____

SECTION B: Please read the following and complete the information requested.

You have the right to request that we restrict our use or disclosure of your protected health information, including for treatment, payment or our health care operations. We are under no obligation to agree to your request. If we do agree, our agreement must be in writing and we will then restrict our use or disclosure of your protected health information as you request.

We may, notwithstanding our agreement, use or disclose the restricted information in an appropriate medical emergency when the information is needed for your treatment, or when you authorize us in writing to use or disclose the information, or when the use or disclosure is required, or in certain situations permitted, by law.

You may end the restriction at any time by notifying us in writing. We may end our agreement to restrict use or disclosure of your protected health information at any time by notifying you in writing. If you agree with our decision to end the restriction, your protected health information will no longer be subject to the restriction. If you disagree, our termination of the restriction will apply only to your protected health information that we receive after we gave you our notice terminating the restriction.

Please specify the protected health information, to be covered by the proposed restriction:

Please state the restriction you want to apply to that protected health information:

SECTION C: Signature

If this request is from the **Member,** please complete the following:

I request that CareConnect restrict the use or disclosure of my protected health information. I understand that CareConnect is under no obligation to agree to my request, and that there will be no agreement unless CareConnect informs me in writing that it agrees to my request.

_____ _____
Signature Print Name

_____
Date

If this request is from a **Personal Representative** on behalf of the member, please complete the following:

I understand that CareConnect is under no obligation to agree to my request, and that there will be no agreement unless CareConnect informs me in writing that it agrees to my request. Please provide documentation of authority to act as the member's personal representative and sign below.

_____ _____
Signature Print Name

Relationship to Individual: _____

Date: _____

Personal Representative: If you are not the member or parent of the minor member, please attach proof of your relationship to the member. We will require verification of your authority to act on the member's behalf before this request will be considered complete. Please attach copies of your authorization as required by state law to represent the member – for example, health care proxy or guardianship papers.

Please return this completed form by:

Fax: (516) 706-3829

Mail:
CareConnect Insurance Company, Inc.
Attention: Privacy Officer
2200 Northern Boulevard, Suite 104 East Hills, NY 11548

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS.