REQUEST FOR RESTRICTION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND CONFIDENTIAL COMMUNICATIONS

If you could be at risk of harm, harassment, or abuse when your protected health information (PHI) is shared, you have the right to request VSP® restrict how PHI about you is used or disclosed or that it be sent directly to you at an alternative address. Restrictions do not apply to emergency treatment or services or when use or disclosure without your written permission is authorized or required by law.

SECTION A: INFORMATION OF INDIVIDUAL REQUESTING RESTRICTION

Last Name:	First Name:	Middle Initial:	Date of Birth (MM/DD/YYYY):

Current Address:	City:	State:	Zip:

Telephone Number (include area code):	Email (optional):

Social Security Number (SSN):	OR	Member ID:

SECTION B: PURPOSE OF REQUEST (Select all that apply.)

☐ **B1: Confidential communications**

I request VSP send claim-related information by alternative means or to an alternative location. Checking this box means VSP will use reasonable efforts to mail correspondence containing PHI to the alternative address.

1. VSP mails communications containing PHI to the address maintained in our system for the individual. We may rely on claims submissions from providers to generate correspondence. VSP will use reasonable efforts to mail correspondence containing PHI to the address you specify on this form.
2. This request will not affect the current residential or mailing address listed in provider or facility systems of records.
3. If you move or otherwise need to change the alternative address, you will need to submit a new form to VSP.
4. If approved, the alternative address may be shown on correspondence about you that VSP sends to others, such as your provider, or upon request of an authorized representative.

Alternative Address:	City:	State:	Zip:

Alternative Telephone Number (optional (include area code)):	

☐ **B2: I request PHI be restricted.**

Specify the PHI or specific episode of care you want to be handled in a restricted manner and provide the name(s) of the person(s) you would like the information to be restricted from (optional):

_____

_____

_____

_____

☐ **B3: I wish to revoke my previously submitted request for restriction.**

SECTION C—SIGNATURE: I have read and understand the information on this request.

1. VSP is not required to approve this request for restriction/confidential communications.
2. If your form is incomplete, you will be notified by mail or telephone and your request will not be considered until a completed form is received, or the missing information is provided.
3. Approved requests apply only to the records maintained by VSP or our business associates. It is not transferable to other providers/facilities, health plans, or other persons or entities outside of VSP; you must obtain their agreement to a restriction separately.
4. VSP is not permitted to restrict access to either parent regardless of custody, unless a court order allows for such an action, or both parents have signed the form. This ensures that both parents are aware of and approve the restriction.
5. While approved restrictions do not prevent you from having access to your own health information or to an accounting of how your health information has been used, access to the online member portal may no longer be available. Access must be requested from VSP by telephone or in writing.
6. Once approved, this restriction can be terminated under the following circumstances:
   a. Upon expiration.
   b. You request the termination in writing.
   c. If VSP informs you that it has decided to terminate the restriction. In this situation, the termination only applies to the health information created or received after the termination is in effect.
7. If VSP denies your request, you will be notified of our decision.

Signature(s) of Individual* or Personal Representative(s)**:	Date (mm/dd/yyyy):
Print Name(s)/Relationship to Individual:	Expiration Date (mm/dd/yyyy):

*If you are a parent or guardian requesting a restriction on a child that will prevent the child's other parent from accessing or receiving the child's PHI, you must:

1. Provide legal documentation showing parental rights of the other parent have been terminated, or access to the child's PHI is prohibited by law.

OR

2. Obtain the other parent's agreement to this restriction. If you obtain the other parent's agreement to this restriction, please provide both signatures on this form or include a statement signed by both parents indicating the both parents agree to place a restriction on the child's PHI.

**If this request is by a personal representative on behalf of the beneficiary, check the box on the right that describes the relationship to the member and attach documentation of the representative's authority.

- ☐ Parent of minor child
- ☐ Legal guardian
- ☐ Power of attorney
- ☐ Executor
- ☐ Other (please explain)_____

Please retain a copy of this for your records

FOR OFFICE USE ONLY

☐ We have approved the requested restriction.

☐ We are unable to approve the following restriction you have requested:
- ☐ Incomplete form
- ☐ Legal documents required
- ☐ Signature(s) required

Initials_____ Date _____

☐ Denied.
- ☐ Invalid legal documents
- ☐ Legal documents not available
- ☐ Unable to accommodate request

☐ VSP has terminated the restriction effective_____.

Initials_____ Date _____

Return completed forms to: VSP Legal Department 3333 Quality Drive, MS 163, Rancho Cordova, CA, 95670 or HIPAA@vsp.com

RESET FORM PRINT SAVE