

Restriction to Use or Disclosure of PHI Request Form



Mail to: Western Health Advantage, Attn: Member Services
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833

Fax to: 916.568.0126

Email to: memberservices@westernhealth.com
Include in Subject Line: Restriction to PHI Request Form

Questions? 916.563.2250, 888.563.2250 toll-free or 888.877.5378 for TDD/TTY

Member Name (First, Last) _____

Date of Birth _____ WHA ID _____

Address _____

Phone Number _____ Email _____

This form will allow a member to request for a restriction on the use and disclosure of Protected Health Information (PHI) or to revoke the restriction placed on the use or disclosure of PHI. WHA will consider all request for restrictions carefully, however, WHA is not required to agree to a requested restriction. Any restriction WHA accepts will be limited to the information under our control.

This request is: (check one)

- New Modified TO REVOKE an existing restriction effective (MM/DD/YY)_____. **Skip to signature line.**

Restriction Requested

- Restriction on use or disclosure relating to treatment, payment and/or healthcare operations

Please provide details _____

- Restriction on use and disclosure of PHI: (check all that apply)

- To a family member, other relative, or other identified person, directly relevant to their involvement with my care or payment for health care services

Provide details (e.g., restricted information and/or name of family member, friend)

- Relating to my location, my general condition or my death to a family member, a personal representative or other person responsible for my care

Provide details (e.g., restricted information and/or name of family member, friend)

- An Account Passcode or Personal Identification Number (PIN) when calling WHA to further secure the account (complete the Account Passcode/PIN Request Form to provide details)

- Other restrictions on use or disclosure

Please provide details _____

I understand and agree to the following:

- If my request is granted, WHA may not use or disclose the PHI in violation of the restriction except as noted below. This request for restriction may be denied and if so, I will be notified in writing of such denial.
- Any restriction agreed to by WHA is not effective to prevent uses or disclosures permitted or required under the HIPAA Privacy Rule, including: for the emergency treatment of the individual whose PHI is under restriction;

disclosures to the Secretary of Health and Human Services; or disclosures for which consent, authorization or opportunity to agree or object is not required.

- If I am not the subscriber to the health plan,
 - and I am enrolled in a high deductible health plan, the subscriber may receive information from a Health Savings Account ("HSA") account administrator (Health Equity or other administrator) regarding services I obtained;
 - Communications will continue to be sent to the current address WHA has on file for the subscriber unless I have submitted a Confidential Communication Request and the same was accepted by WHA;
 - Placing restrictions may limit my or the subscriber's access to the online account (myWHA or app).
- If this request is granted, it will be processed within seven (7) days of receipt of the request by electronic transmission or within 14 days of receipt by first-class mail.
- I may revoke this restriction in writing at any time by mailing or delivering the request to Member Services, Western Health Advantage, 2349 Gateway Oaks Dr., Suite 100, Sacramento, CA 95833. The termination will be effective with respect to any PHI created or received after the termination date.
- This request must be accompanied by a copy of a form of photo ID, unless one is already on file with WHA.

WHA Member

Signature _____

Name (Print) _____ Date _____

Personal Representative

Signature _____

Name (Print) _____ Date _____

Please check the box that describes your relationship to the member:

- Parent of Minor Legal Guardian Power of Attorney Executor
- Other _____

Documentary proof of your relationship/authorization must be attached to this request, otherwise it cannot be processed or may be denied. If you are requesting the restriction on a minor,

- (a) Federal and state laws may prohibit WHA from acting on your request about information relating to sensitive services without written authorization from the minor 12 years of age or older.
- (b) If the restriction will prevent the child's other parent from accessing PHI, you must either provide evidence that the parental rights of the other parent has been terminated, or obtain the other parent's signature to this restriction form and have it notarized.

WHA Internal Use Only

Date Request Received _____

Member Identification Verified _____ documents checked

Date Request Fulfilled or Denied _____

If Denied, Reason for Denial _____

Signature of Manager or Supervisor _____

Name (Print) _____ Date _____

Western Health Advantage complies with applicable Federal and California civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, as applicable. Western Health Advantage does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Western Health Advantage:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Member Services Manager at 888.563.2250 and find more information online at <https://www.westernhealth.com/legal/non-discrimination-notice/>.

If you believe that Western Health Advantage has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance by telephone, mail, fax, email, or online with: Member Services Manager, 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833, 888.563.2250 or 916.563.2250, 888.877.5378 (TTY), 916.568.0126 (fax), memberservices@westernhealth.com, <https://www.westernhealth.com/legal/grievance-form/>. If you need help filing a grievance, the Member Services Manager is available to help you. For more information about the Western Health Advantage grievance process and your grievance rights with the California Department of Managed Health Care, please visit our website at <https://www.westernhealth.com/legal/grievance-form/>.

If there is a concern of discrimination based on race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

Website: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>; Mail: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; Phone: 800.368.1019 or 800.537.7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ENGLISH

If you, or someone you're helping, have questions about Western Health Advantage, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 888.563.2250 or TTY 888.877.5378.

SPANISH

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Western Health Advantage, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 888.563.2250, o al TTY 888.877.5378 si tiene dificultades auditivas.

CHINESE

如果您，或是您正在協助的對象，有關於Western Health Advantage方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話888.563.2250或聽障人士專線(TTY) 888.877.5378。

VIETNAMESE

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Western Health Advantage, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số 888.563.2250, hoặc gọi đường dây TTY dành cho người khiếm thính tại số 888.877.5378.

TAGALOG

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Western Health Advantage, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 888.563.2250 o TTY para sa may kapansanan sa pandinig sa 888.877.5378.

KOREAN

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Western Health Advantage에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 888.563.2250이나 청각 장애인용 TTY 888.877.5378로 연락하십시오.

ARMENIAN

Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի Western Health Advantage-ի մասին, Դուք իրավունք ունեք անվճար օգնություն և տեղեկություններ ստանալու Ձեր նախընտրած լեզվով: Թարգմանչի հետ խոսելու համար զանգահարե՛ք 888.563.2250 համարով կամ TTY 888.877.5378՝ լսողության հետ խնդիրներ ունեցողների համար:

PERSIAN-FARSI

گر شما، یا کسی که هم به او کمک میکنید ، سوال در مورد Western Health Advantage (وسترن هلث کونتیج) داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. لطفاً با شماره تلفن 888.563.2250 تماس بگیرید. افراد ناشنو می توانند به شماره 888.877.5378 پیام تاپیی ارسال کنند

RUSSIAN

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Western Health Advantage, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 888.563.2250 или воспользуйтесь линией TTY для лиц с нарушениями слуха по номеру 888.877.5378.

JAPANESE

ご本人様、またはお客様の身の回りの方でも、Western Health Advantageについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、888.563.2250までお電話ください。聴覚障がい者用TTYをご利用の場合は、888.877.5378までお電話ください。

ARABIC

إن كان لديك أو لد شخص تساعد أمثلة بخصوص Western Health Advantage، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 888.563.2250، وأ بركة لمهااتف النصي (TTY) لضعاف السمع 888.877.5378.

PUNJABI

ਜੇਕਰ ਤੁਸੀਂ, ਜਾਂ ਜਿਸ ਕਿਸੇ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਦੇ Western Health Advantage ਬਾਰੇ ਸਵਾਲ ਹਨ ਤਾਂ, ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਆਰਾ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 888.563.2250 'ਤੇ ਜਾਂ ਪੂਰੀ ਤਰ੍ਹਾਂ ਸੁਣਨ ਵਿੱਚ ਅਸਮਰਥ ਟੀਟੀਵਾਈ ਲਈ 888.877.5378 'ਤੇ ਕਾਲ ਕਰੋ।

CAMBODIAN-MON-KHMER

ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលកំពុងជួយអ្នក មានសំណួរអំពី Western Health Advantage ទេ, អ្នកមានសិទ្ធិទទួលជំនួយនឹងព័ត៌មាននៅក្នុងភាសារបស់អ្នក ដោយមិនអស់ប្រាក់។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូមទូរស័ព្ទ 888.563.2250 ឬ TTY សម្រាប់អ្នកត្រចៀកច្រន់ តាមលេខ 888.877.5378។

HMONG

Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Western Health Advantage, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 888.563.2250 los sis TTY rau cov neeg uas tsis hnov lus zoo nyob ntawm 888.877.5378.

HINDI

यदि आप, या जिस किसी की आप मदद कर रहे हो, के Western Health Advantage के बारे में प्रश्न हैं तो, आपको अपनी भाषा में मदद तथा जानकारी प्राप्त करने का अधिकार है। दुआशिए के साथ बात करने के लिए, 888.563.2250 पर या पूरी तरह श्रवण में असमर्थ टीटीवाई के लिए 888.877.5378 पर कॉल करो।

THAI

หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Western Health Advantage คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย เพื่อพูดคุยกับล่าม โทร 888.563.2250 หรือใช้TTY สำหรับคนหูหนวกโดยโทร 888.877.5378