Member Name: _____
Planholder SSN:_____ Date: _____
Member Relationship to Planholder _____

Request for Restriction on Use or Disclosure of Your Protected Health Information

I. Your Protected Health Information

The Kentucky Employees' Health Plan ("KEHP") collects and maintains protected health information ("PHI") that includes personal identifiers, enrollment, eligibility, and dependent and qualifying event information. KEHP utilizes a third-party claims administrator and a pharmacy benefits manager, referred to as "Business Associates," to carry out certain functions for KEHP. Because of their administrative responsibilities, these Business Associates create, receive, maintain, and transmit PHI on behalf of KEHP. Like KEHP, the Business Associates are responsible for ensuring the protection of your health information.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), KEHP and its Business Associates may use and disclose your PHI for treatment, payment, or health care operations including, but not limited to, claims processing, billing, case management, provider credentialing, and utilization review. Other uses and disclosures permitted or required by HIPAA are outlined in KEHP's Notice of Privacy Practices.

II. Your Rights

You have the right to request KEHP to restrict uses and disclosures of PHI about you to carry out treatment, payment, or health care operations. You may also request KEHP to restrict uses and disclosures of your PHI to family members, relatives, close personal friends, or other persons identified by you who are involved in your health care or payment for that care.

KEHP is not required to agree to your requested restriction except when (1) the disclosure is for the purpose of carrying out payment or health care operations, (2) the disclosure is not otherwise required by law, and (3) the PHI pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid in full.

III. Request for Restriction on Uses and Disclosures of Your PHI

(a) I request to restrict:
(Check all that apply. For each restriction, check whether you want to restrict KEHP's use or disclosure or both.)

☐ KEHP's [☐ use] or [☐ disclosure] of my PHI regarding treatment.
☐ KEHP's [☐ use] or [☐ disclosure] of my PHI regarding payment for my health care
☐ KEHP's [☐ use] or [☐ disclosure] of my PHI regarding health care operations.
☐ KEHP's [☐ use] or [☐ disclosure] of my PHI to family members, relatives, close personal friends, or other persons identified by me who are involved in my health care or payment for that care.

(b) I request that the restrictions requested above apply to the following specific information:

_____
_____

Member Name: _____
Planholder SSN:_____ Date: _____
Member Relationship to Planholder _____

(c) I request that the use and disclosure of the information described in (b) above be restricted in the following manner: _____

(d) I request that my PHI not be disclosed to the following individuals or entities:

_____

IV. Limitations and Termination of a Requested Restriction

If KEHP agrees to a restriction, either you or KEHP may terminate this restriction at any time. If KEHP informs you that it is terminating its agreement to a restriction, the termination of the restriction is only effective with respect to PHI created or received after KEHP informs you of the termination.

If KEHP agrees to a requested restriction on certain uses and disclosures, KEHP will notify you of such agreement and will not use or disclose PHI in violation of such restriction except where the restricted information is needed to provide emergency treatment. If restricted PHI must be used or disclosed to provide emergency treatment to you, then this restriction is void as it relates to this limited use or disclosure. If a restriction is agreed to by KEHP, it is not effective to prevent uses or disclosures required by the Secretary of the U.S. Department of Health and Human Services to investigate KEHP's compliance with HIPAA or uses or disclosures that are otherwise required by law. If a restriction is not specifically listed above and agreed to in writing by KEHP, it will not be effective.

V. Signature of Member or Member's Personal Representative *(Form MUST be completed before signing.)*

By signing below, I am indicating that I understand my rights regarding requested restrictions on uses and disclosures of my PHI. I also understand the limitations and termination provisions regarding my requested restrictions.

_____
Printed Name of Member

_____
Printed Name of Member's Personal Representative
(If Applicable)

_____
Signature of Member or
Member's Personal Representative

_____
If a Personal Representative – Describe Relationship to Member. Include authority/documentation proving status as a Personal Representative.

Date:_____

Remit Form To:

Sharron S. Burton, Privacy Officer
Office of Legal Services
Personnel Cabinet
501 High Street, 3rd Floor
Frankfort, KY 40601
Fax: (502) 564-7603
Sharron.Burton@ky.gov

VI. KEHP Response to Your Request for Restriction

In response to your request for a restriction on the use and disclosure of your PHI, KEHP:

☐ Agrees to the restriction as requested.
☐ Agrees to the restriction with modifications as follows:

_____
_____

☐ Does not agree to the restriction as requested.

_____
Signature of KEHP Privacy Officer

Date:_____
Date Copy Mailed to Member: _____