Request for Restriction of Records

ENPOINTE FLEXIBLE SPENDING PLAN – MEDICAL REIMBURSEMENT ACCOUNT

Health Plan/OHCA Name

I hereby request to restrict the use and disclosure of some or all of my medical record as follows:

- ☐ Separate document attached.
- ☐ As described below:

_____

_____

_____

I understand that the plan of which I am requesting this restriction is not obligated to allow it under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the regulations therein. I will be notified of their decision within 60 days.

If this restriction is allowed, it will be maintained as part of my medical record for as long as this office holds the record, and this office may not use or disclose protected health information in violation of this restriction, except in emergency situations or to public health, government or law enforcement officials with the proper documentation.

I also understand that I have the right to cancel this restriction in writing or orally (as long as the oral agreement is documented) at any time and that this office may inform me that it is terminating its agreement to a restriction and then may freely use or disclose protected health information created or received after it has so informed me.

Covered Person:	
Name:	Relationship:
Signature:	Date:

I am exercising my right to cancel this restriction. I understand that by canceling this restriction this office may now freely use my protected health information for treatment, payment or health care operations.

Covered Person:	
Name:	Relationship:
Signature:	Date:

OFFICE USE ONLY		
Reviewed By:	Initials:	Date:
Decision: ☐ Approved ☐ Denied ☐ Response	Decision Notification Sent:	
Response approved by:		Date: