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## Request to Restrict Use and/or Disclosure of Protected Health Information

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HIPAA Privacy Regulations allow an individual to request that a health plan and its business associates restrict their uses and/or disclosures of that individual's Protected Health Information. However, the regulations do not require that the request is honored. United Behavioral Health(UBH), and its affiliate U.S. Behavioral Health Plan of California (USBHPC), understand the importance of maintaining the confidentiality of its members' behavioral health information. As a result, UBH uses and discloses member level information only as necessary to provide services to our customers and as permitted and required by law. Therefore, UBH is unable to honor most requests to further restrict the ways in which we use and/or disclose individually identifiable health information. To do so would seriously impair our ability to provide quality behavioral health care benefits to you. We will consider all restriction requests, but will only be able to honor extraordinary ones. This is why we ask you to describe the reason(s) for your request.

When completing this form, please:

- Complete all sections entirely;
- Print information clearly;
- Provide us with your most current information.

**Please note:** If you are a guardian or court appointed representative for the individual you must attach copies of your authorization to represent the individual in order to obtain access to their Protected Health Information.

We can only process your request with respect to behavioral health benefits administered by United Behavioral Health or its affiliates. To process a request for restriction of your PHI concerning your medical, dental or any other covered entity benefit not managed by UBH or its affiliates, you must contact the entity that administers those benefits directly.

If you have any questions about filling out this form, please contact 1-866-604-3273 and dial "0" to speak with a Customer Service Representative.

## Request to Restrict Use and/or Disclosure of Protected Health Information

This form is used to request a restriction on the way United Behavioral Health uses and/or discloses your Protected Health Information contained in a Designated Record Set that has been created by United Behavioral Health. Once the decision to grant or deny your request has been made, a letter will be mailed to you or your authorized personal representative. Please print.

### Section 1: Restriction Requested For:

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number (\_\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Relationship to Subscriber: Self \_\_\_ Spouse \_\_\_ Child \_\_\_ If other, describe type of relationship \_\_\_\_\_

### Section 2: Specific Restriction Requested:

Please indicate the way(s) in which you would like United Behavioral Health to restrict the ways in which it uses and/or discloses your Protected Health Information and the specific reason(s) for your request.

### Section 3: Signature of Member or His/Her Personal Representative:

**Authorized signature of individual or personal representative of individual for whom the restriction is being requested:**

Signature of Individual: X \_\_\_\_\_ Date \_\_\_\_\_

Signature of Personal Representative if applicable: X \_\_\_\_\_ Date \_\_\_\_\_

Representative's Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone Number (\_\_\_\_\_) \_\_\_\_\_

Relationship to individual and authority to act for individual \_\_\_\_\_

**Important: A personal representative, including a parent, legal guardian, or executor of an estate may be required to attach a copy of legal documentation to this request form. If you have questions please call 1-866-604-3273 and dial "0" for a Customer Service Representative who can answer your questions about legal documentation.**

### Section 4: United Behavioral Health Subscriber Identification:

Subscriber Identification Number \_\_\_\_\_ Group Number \_\_\_\_\_ Employer \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

**Please return the completed form to:**  
United Behavioral Health  
Compliance Department – Privacy Lead  
P.O. Box 99378  
Emeryville, CA 94662-9378