# **Request to Restrict Access to My Health Information**

Usted puede recibir este documento en otro idioma, impreso en una letra más grande o de otra manera que sea mejor para usted. También puede solicitar un intérprete. Esta ayuda es sin costo. Llame al 800-431-4135 o por TTY al 711. Aceptamos llamadas del servicio de retransmisión.

*You can get this document in another language, large print, or another way that is best for you. You can also request an interpreter. This help is free. Call 800-431-4135 or TTY 711. We accept all relay calls.*

**You are asking to limit the use and/or disclosure of your health information.**

You have the right to ask PacificSource not to use or share your information.

**If we agree to your request, we will let you know in writing.**

We will try to do what you ask, but we do not have to agree to your request**.**

**Need help or have questions?**

Chat with us through our secure member portal, InTouch for Members. Sign in or create your account at [PacificSource.com/Medicaid](https://pacificsource.com/medicaid). Click the chat icon in the lower right corner for help from our Customer Service team.

You can also reach us by phone at 800-431-4135, TTY: 711. We accept all relay calls. We are open:

• October 1 to March 31: 8:00 a.m. to 8:00 p.m. local time, seven days a week

• April 1 to September 30: 8:00 a.m. to 8:00 p.m. local time, Monday to Friday

**All sections must be complete for this form to be good.**

|  |
| --- |
| **Member Information** |
| First name | Last name |
| Date of birth | Member ID | Group number |
| Member address |
| City | State  | Zip |
| Phone |

**Your rights when asking for restriction of information:**

* You have a right to request restriction on the uses and disclosures of your information.
* You have a right to have an answer to your request within 60 days. If there are delays in getting you the answer you will be notified in writing and this delay cannot be more than 30 days.
* If PacificSource agrees to your request, the restricted information will not be used or disclosed unless PacificSource ends the agreement.
* Information in our record that was created or received while the restriction was in place will remain subject to the restrictions.
* Your request and the answer will be kept in your record.

**I am asking to limit the following information from being used and/or disclosed**

***(be specific):***

|  |
| --- |
| 1) |
| 2) |
| 3) |

**Please sign below and submit the completed form to us one of these ways:**

* Email:  CommunitySolutionsCS@PacificSource.com
* Mail: PacificSource Community Solutions

 PO Box 5729

 Bend, OR 97708-5729

* Fax: 541-322-6423

|  |
| --- |
| **Signature of Member or Representative** |
| Signature | Date |
| Printed name of representative (if applicable) |
| Representative relationship to member |
| **Note:** Upon request, you may be required to provide all legal documentation proving your relationship to the member. |