Form 10326

HIPAA RESTRICTION REQUEST

This form is for use by West Region beneficiaries or an authorized representative to request that a restriction be placed on the **use** and **disclosure** of the beneficiary's protected health information (PHI).	
SECTION A: Individual Requesting Restriction	
Name:	
Address:	
Telephone:	Email:
Social Security Number:	Sponsor:
Beneficiary:	
TO THE BENEFICIARY: Please read the following and complete the information requested.	
• You have the right to request that TriWest Healthcare Alliance (TriWest) restrict its use of your PHI for treatment, payment or health care. If TriWest agrees with your request, you will be notified in writing. TriWest may use or disclose the restricted information when needed to treat you in a medical emergency or when required or authorized by law. • Either you or TriWest may end a restriction agreement at any time by notifying the other in writing. To exercise your right to request restriction on our use or disclosure of your PHI, please complete Section B. • Restrictions will expire for minors when they reach the age of majority.	
SECTION B: Restriction Requested	
Please specify the PHI, the use or disclosure of which you want to restrict.	
Please state the restriction you want to apply to that PHI. (If you would like to have a password placed on your account that must be provided before a TriWest representative will disclose your PHI, please provide the password you would like to use.)	
SIGNATURE OF BENEFICIARY OR AUTHORIZED REPRESENTATIVE: Date:	
If this request is by a personal representative on behalf of the beneficiary, complete the following:	
Personal Representative's Name:	
Relationship to Beneficiary:	
YOU ARE ENTITLED TO A COPY OF THIS REQUEST.	

Please submit the completed and signed request to:
TriWest Healthcare Alliance
Attn: HIPAA Privacy Official
P.O. Box 2585
Virginia Beach, VA 23450
Fax: 877-875-1340