REQUEST FOR RESTRICTION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND CONFIDENTIAL COMMUNICATIONS

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personal information required by Health Net Federal Services, LLC (HNFS) on behalf of the TRICARE program in order to accommodate your request, and how it will be used.

AUTHORITY: 10 U.S.C. Chapter 55; 38 U.S.C. Chapter 17; 32 CFR Part 199, and E.O.9397 (SSN), as amended.

PURPOSE: Provides a beneficiary or his/her uthorized representative with a means to request a restriction on the use and disclosure of his/her protected health information (PHI) and/or to request confiden ial communications.

ROUTINE USES: Your information may be disclosed in order to investigate waste, fraud and abuse, security, and privacy concerns. Use and disclosure of your records outside of DoD may occur in accordance with the DoD Blanket Routine Uses published at http://dpclo.defense.gov/privacy/SORNs and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Any PHI in your records may be used and disclosed as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), and includes purposes of treatment, payment, and health care operations.

DISCLOSURE: Voluntary; if you choose not to provide your information, no penalty may be imposed, but absence of the requested information may result in administrative delays or the inability to process your request.

Please submit the completed request to:

Health Net Federal Services, LLC
Attention: Privacy Compliance Office
PO Box 989734
West Sacramento, CA 95798-9734
FAX: 1-844-813-7788
HNFS.Privacy@hnfs.com

You have the right to request HNFS restrict how PHI about you is used or disclosed for treatment, payment or health care operations. *Restrictions do not apply to emergency treatment or services, or when use or disclosure without your written permission is authorized or required by law.*

SECTION A: INDIVIDUAL/BENEFICIARY INFORMATION

Last Name	First Name	Middle Initial	Date of Birth (mm/dd/yyyy)

Current Address	City	State	ZIP

Telephone Number	Email
( )	

Sponsor Social Security Number (SSN)	OR	Beneficiary DoD Benefits Number (DBN)

SECTION B: PURPOSE OF REQUEST: Please check all applicable boxes

☐ **B1: Confidential communications: I request to receive certain communications from HNFS at an alternative location or by alternative means.**

Checking this box means HNFS will use reasonable efforts to mail correspondence containing PHI to the alternative address.

HNFS mails communications containing PHI to the address maintained in our system for the member. We may rely on TRICARE, enrollment files, he Defense Enrollment Eligibility Reporting System (DEERS), or submissions from providers for service authorizations to generate correspondence. HNFS will use reasonable efforts to mail correspondence containing PHI to the address you specify on this form.

This request will not affect the current residential or mailing address listed in any other military system of record.

This address will not be updated when DEERS, enrollment or other addresses are updated. If you move or need to change the alternative address, you will need to submit a new form to your regional contractor.

If approved, the alternative address or telephone number may be shown on correspondence about you that HNFS sends to others, such as your provider, or upon request of an authorized representative.

Alternative Address	City

State	ZIP	Alternative Telephone Number
		( )

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☐ **B2: Password request: I request a password be placed on an account profile.**

HNFS verifies every caller's identity, confirming a minimum of three personal identifiers (for example, full name, sponsor SSN, date of birth, residence address). If you feel this information may be known to another individual, you may request a personal password be applied to your individual account profile to prevent the unauthorized disclosure of PHI. The password provides an added layer of security and is considered a fourth mandatory identifier before PHI about you is released during telephone interactions. Passwords are not required for providers calling about your care.

Please select a hint question:

☐ What was your high school mascot? ☐ What was the name of your first pet? ☐ What was the name of your first stuffed animal?
☐ What is your favorite car? ☐ What is your favorite sports team? ☐ What was your favorite childhood TV show or movie?

Provide a password that corresponds to the hint question: ______________________________

Additional restriction information/details.

Specify the PHI or specific episode of care you want to be handled in a restricted manner and provide the name(s) of the person(s) you would like the information to be restricted from:

____

____

☐ **B3: Revoke previous request: I wish to revoke my previously submitted request for restriction.**

1. HNFS is not required to approve this request for restriction/confidential communications.
2. If your form is incomplete, you will be notified by mail or telephone and your request will not be considered until a completed form is received, or the missing HNFS information is provided.
3. Approved requests apply only to the records maintained by HNFS or our business associates for the TRICARE West Region. It is not transferable to other providers/facilities, health plans, or other persons or entities outside of HNFS; you must obtain their agreement to a restriction separately.
4. HNFS is not permitted to restrict access to either parent regardless of custody, unless a court order allows for such an action, or both parents have signed the form. This ensures that both parents are aware of and approve the restriction.
5. Approved restrictions do not prevent you from having access to your own health information or to an accounting of how your health information has been used.
6. If your military sponsor changes, you may need to complete and submit a new form at that time.
7. Once approved, this restriction can be terminated one of the following ways:
   a. Upon expiration,
   b. You request the termination in writing,
   c. You request the termination verbally from the HNFS Privacy Compliance Office and it is documented by HNFS, or
   d. If HNFS/Defense Health Agency (DHA) informs you it has decided to terminate the restriction. In this situation, the termination only applies to the health information created or received after the termination is in effect.
8. If HNFS denies your request, you and DHA will be notified of our decision.

I DECLARE UNDER PENALTY OF PERJURY THE INFORMATION ON THIS FORM AND ANY ATTACHED DOCUMENTS IS TRUE AND CORRECT. ANY ATTEMPT TO FALSELY GAIN ACCESS TO PHI IS SUBJECT TO LEGAL PENALTIES.

______________________________ ______________________________
Signature(s) of Beneficiary, Parent(s)* or Personal Representative(s)** Date *(mm/dd/yyyy)*

______________________________ ______________________________
Print Name(s) and Relationship to Beneficiary Expiration Date

* If you are a parent or guardian requesting a restriction on a child that will prevent the child's other parent from accessing or receiving the child's PHI, you must:
  – Provide legal documentation showing parental rights of the other parent have been terminated, or access to the child's PHI is prohibited by law; or
  – Obtain the other parent's agreement to this restriction. If you obtain the other parent's agreement to this restriction, please provide both signatures on this form or include a statement signed by both parents indicating each agree to place a restriction on the child's PHI.

**If this request is by a personal representative on behalf of the beneficiary, check the box that describes the relationship to the beneficiary and attach documentation of the representative's authority.

☐ Parent of minor child ☐ Legal guardian ☐ Power of attorney ☐ Executor ☐ Other (please explain) ______________________________

Please retain a copy of this request for your records.