Missouri Consolidated Health Care Plan

# Request for Restriction on Use & Disclosure of Health Care Information and/or Confidential Communication

Public Entity Account

**Submit this form**
**Online:** Upload through myMCHCP **Fax:** 800-834-5181
***Mail:*** PO Box 104355
Jefferson City, MO 65110-4355

**PE RUD**

*Revised 12/2021*

## Instructions

If you need assistance in completing this form, please contact MCHCP at 800-487-0771.

## Section 1: Member Information

**Name (Last, First, MI):** ☐ New Name

**Address**: ☐ New Address

**City**: **State**: **Zip Code**:

**MCHCP ID**:
*OR*
**Social Security Number**: - -

**Primary Phone**: ☐Home ☐Work ☐Cell ( ) -

**Secondary Phone**: ☐Home ☐Work ☐Cell ( ) -

## Section 2: Information Restriction and Confidential Communication

Please fill out Column A **and/or** Column B:

| Column A | Column B |
|---|---|
| **Health Care Information to be Restricted (Please specify what infor-mation should be restricted):** | **Health Care Information to be Communicated Confidentially:** |
| **Nature of Restriction (Please specify to whom the information should be restricted. Ex - health plan vendor, medical provider, relative, etc.):** | **Preferred Alternative Location/Address/Telephone Number/Email:** |

## Section 3: Subscriber Authorization

You have the right to request that we restrict our use and disclosure of your health care records and information. We do not have to agree to your requested restrictions. If we do agree to the requested restriction, we will abide by the restriction unless an emergency requires otherwise. You also have the right to request that we communicate certain health care information to you in confidence. We will accommodate your rea-sonable written requests to receive communications of health information by alternative means or at alternative locations only if you specify the alternative location, address, or telephone number and/or the alternative means of contact.

**Signature of Member**: **Date** (MM/DD/YYYY): / /

**Or, Signature of Person Authorized by Law to Act for the Member (Attach proof of authority to act):** **Date** (MM/DD/YYYY): / /

## MCHCP STAFF ONLY

Reason for Restriciton: ☐ Accepted ☐ Denied Request to Communicate Confidentially: ☐ Accepted ☐ Denied

This Request for Restriction and/or Confidential Communication Form is to be made a part of the medical record of (Member Name):

*Return a copy of completed form to individual and place original as part of individual's medical record.*