



Missouri Consolidated Health Care Plan

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

State Members

Submit this form

Online: Upload through myMCHCP

Fax: 866-346-8785

Mail: PO Box 104355

Jefferson City, MO 65110-4355

ST RUD

Revised 04/2024

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:

Table with 2 columns: Column A (Health Care Information to be Restricted) and Column B (Health Care Information to be Communicated Confidentially). Includes sub-sections for Nature of Restriction and 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.

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 Restriction: [] 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.