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Missouri Consolidated Health Care Plan
573-751-0771 · 800-487-0771 · www.mchcp.org
832 Weathered Rock Court, Jefferson City, MO 65101

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

State Members ***Please print clearly and fill out this form completely.***

Submit this form:
- **Online**: Upload through myMCHCP
- **Fax**: 866-346-8785
- **Mail**: PO Box 104355, Jefferson City, MO 65110-4355

MCHCP Use Only

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Instructions

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

Section 1 – Member Information

Member Name (Person wanting to restrict information):

_____

Address:

_____

City: _____ **State**: _____ **ZIP Code**: ___ ___ ___ ___ ___

MCHCPid (Provide **either** MCHCPid or Social Security Number)

___ ___ ___ ___ ___ – ___ ___ ___ ___ ___

or **Social Security Number**:

___ ___ ___ – ___ ___ – ___ ___ ___ ___

Primary Phone Number: ❑ Home ❑ Work ❑ Mobile

(___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

Secondary Phone Number: ❑ Home ❑ Work ❑ Mobile

(___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

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 information 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 – Member 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 reasonable 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

Request 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.