Request for a Restriction on Protected Health Information

Federal law says that you have the right to request a restriction on certain uses and disclosures of your protected health information. The Agency is not required to agree to a restriction.

Information Identifying the Individual Whose Records Are Being Restricted

Name of Individual: _____ SSN: _____

Disclosure of your Social Security Number is not mandatory. The Agency for Health Care Administration may request your Social Security Number pursuant to Section 119.071, Florida Statutes. If provided, the Agency will use your information for purposes of finding the requested information.

Medicaid ID or Gold Card Number: _____

Phone Number: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Information to be Restricted or Person(s) to Apply Restriction to

☐ I request that the Agency for Health Care Administration restrict the use and disclosure of my protected health information regarding the following person(s): *Provide the names of any family members, friends, relatives, etc. that are involved in your care or payment of your care and to whom you do **NOT** want the Agency to disclose information:*

_____

_____

☐ I request that the Agency for Health Care Administration restrict the use and disclosure of my protected health information in the following way(s):

_____

_____

I DECLARE UNDER PENALTY OF LAW THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

Signature: _____ Date: _____

Printed Name: _____

Legal Authority if Other Than Individual: _____

If you are a legal representative of the person whose information you are restricting, you must provide documentation proving your legal authority to request this information (for example, power of attorney, guardianship papers, health care surrogate form, Order Appointing Personal Representative, Letters of Administration).

Your Right to Restrict Your Protected Health Information

You have a right to request a restriction on certain uses and disclosures of the protected health information about you that is in the Agency for Health Care Administration records. You may request restrictions on uses and disclosures for treatment, payment, and health care operations; information to individuals involved in your care; and information for disaster relief purposes. You may submit your request directly to the Privacy Officer at the address given at the bottom of this page or to your Field Office, which will forward it to the Privacy Officer.

The Agency is not required to agree to a restriction.

If you are in need of emergency treatment, and the restricted information is needed to provide the emergency treatment, the Agency may disclose this information.

The Agency may terminate its agreement to a restriction if:

- You request the termination; or
- The Agency informs you that it is terminating its agreement to the restriction. A termination will only apply to protected health information that the Agency creates or receives after it informed you about the termination of the restriction.

If you have any questions about restricting your protected health information, call or write to:

Privacy Officer
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #4
Tallahassee, Florida 32308
Phone: 850-412-3960 FAX: 850-414-6837
HIPAAComplianceOffice@AHCA.MyFlorida.com

Termination of Restriction

DO NOT COMPLETE IF THIS IS A NEW RESTRICTION. To **TERMINATE** your restriction, please complete the following section and send the form to the Privacy Officer at the address given above.
Disclosure of your Social Security Number is not mandatory. The Agency for Health Care Administration may request your Social Security Number pursuant to Section 119.071, Florida Statutes.

Name			Date of Birth		
Phone			Social Security Number		
Medicaid ID Number or Gold Card Number					
Street Address					
City		State		Zip Code	

I hereby terminate my restriction for the Agency for Health Care Administration to use and disclose my protected health information for the following reasons and/or to the following person(s):

Signature		Date	
Printed Name		Legal Relationship to Individual	

If you are a legal representative of the person whose restriction you are terminating, you must provide documentation proving your legal authority to request this revocation. (For example, an authorization, power of attorney, guardianship papers, health care surrogate form, Order Appointing Personal Representative, Letters of Administration).