MOLINA® HEALTHCARE

Request for Special Privacy Protections

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have a right to request that we restrict our uses and disclosures of your protected health information with respect to treatment, payment and health care operations. You also have a right to request that we restrict our uses and disclosures of your health information with respect to disclosures to members of your family and other relatives or close personal friends or other person(s) you identify who are involved in your care or payment for your care, or to notify or assist in notifying those individuals of your location, general condition or death.

PLEASE PRINT:

Member Name: _____ Date of Birth: _____

Address: _____

_____

Member ID# _____ Phone: _____

I hereby request privacy protection for:

_____

_____

_____

This is a complete list of all restrictions requested:

☐ I do not want my Protected Health Information (PHI) be disclosed to any of the following (attach additional pages if needed):

Name: _____

Address: _____

_____

_____

☐ I do not want my PHI used or disclosed for any of the following purposes (attach additional pages if needed):

_____

_____

_____

_____ _____

Signature of member or member's personal representative | Date

_____ _____

Printed name of member's personal representative, if applicable | Relationship to member or personal representative's authority to act for the member, if applicable