Member Health Information Restriction Request Form

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sanfordhealthplan.com

SANFORD HEALTH PLAN

I, _____, hereby request a restriction be placed on the use and disclosure of my protected health information for treatment, payment, insurance or health care operations purposes by Sanford Health Plan.

Please specify the type of restriction(s) you are requesting:

- □ All communications
- □ Printed communications (mail)
- □ Verbal communications (phone)
- □ Electronic communication email
- □ Other (please specify) _____

What person(s) or facility(ies) does this restriction apply to?

_____

NOTE: If you maintain a flexible spending account **with auto processing** (or are a dependent on a flexible spending account), auto processing will be **automatically deactivated** to ensure information is not shared with other members on the policy.

I understand that Sanford Health Plan is not required to agree to my restriction request, but is only required to attempt to accommodate reasonable requests when appropriate. I further understand Sanford Health Plan reserves the right to end an agreed-upon restriction if Sanford Health Plan deems appropriate. I also understand I also have the right to end this restriction by completing a Health Information Disclosure Form and returning to Sanford Health Plan.

_____
Print Member name

_____
Name of personal representative (if Member unable to sign) Relationship to Member

_____
Signature of Member (or Member's representative) Date

INTERNAL USE ONLY
Restriction is _____ Approved _____ Denied _____ Needs review by Health Plan Compliance
Flexible spending auto processing confirmation _____
Comments_____
Authorized by _____ Department _____ Date _____
TERMINATION REQUEST
Terminated by ____Organization ____Member Effective Date_____
Authorized by _____ Department _____
* Attach updated Health Information Disclosure Form to this document.