Request for Restrictions on Use and Disclosure of Health Information

Identification

Member Name:____________________________Date of Birth:_________Member ID #:______________

Member Address:____
Street Apt # City State Zip

Member Home Phone #: (____)__________________ Member Wk. Phone #: (____)__________________

Request

I understand that I may request restrictions on specified uses and disclosures of my health information. As such, I hereby request restriction of the use and disclosure of my health information that is created or maintained by this company in the following circumstances:

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_______________________________________ _______________________
Signature Date

____
Personal Representative Authority

<u>This Section for Company Use Only</u>

❑ Request APPROVED

Company Requirements;
- ❑ Notification to staff of restrictions
- ❑ Notification to other person(s), as needed

❑ Request DENIED

Reason for Denial:
- ❑ May prevent or delay effective treatment
- ❑ Disclosure required by law
- ❑ Other

By: ______________________ ______________________ ______________
Staff Title Date

carolina complete health

How To Submit This Form to Carolina Complete Health

You may submit this form in two ways:

By Mail

Please mail the request to:

Carolina Complete Health
Attn: Privacy Office
1701 North Graham Street
Suite 101
Charlotte, NC 28206

By Email

You may email the completed PDF as an Email attachment to:

CCH_Compliance@carolinacompletehealth.com

Support

If you need help in submitting this document, you may reach out to Member Services at 1-833-552-3876 (TTY 711), Monday-Saturday 7 AM - 6 PM EST.