



**REQUEST FOR THE RESTRICTION OF USE AND/OR DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

Affiliate Name: _____
(Please Type)

Contract Number: _____

Date of Birth: _____

Address: _____

Telephones: Home: _____ Cellular: _____ Other: _____

Specifically describe what Protected Health Information you request to be restricted:

I understand that a disclosure of Protected Health Information might be required by law under certain situations. For example: reporting contagious diseases, child abuse, domestic violence, attempt of suicide, national security, etc.

I, _____, hereby certify my request for restriction.
Insured Name (Please Print)

Insured or Authorized Representative Signature Date

Privacy Unit Representative Signature Date

Witness (If necessary) Signature Date

For Privacy Unit Use Only:

___ Request Accepted
___ Request Denied Reason: _____
___ Subscriber was notified Date: _____

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ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-627-8183 (TTY: 1-866-627-8182). ATTENTION: If you speak English, language assistanceservices, free of charge, are available to you. Call 1-866-627-8183 (TTY: 1-866-627-8182).注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-627-8183 (TTY: 1-866-627-8182)。

Confidentiality Notice: This communication is privileged and confidential, and/or protected health information (PHI) or electronic protected health information (ePHI), and may be subject to protection under the law, including HIPAA. This communication is intended for the sole use of the individual or entity to whom it is addressed. If you are not the intended recipient, be advised that any use, disclosure, distribution, copying, or action taken in reliance on the contents of this communication is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for its return.