SAN JOSÉ STATE UNIVERSITY

PART I - REQUEST FOR RESTRICTED USE OF PERSONAL HEALTH PLAN INFORMATION

HUMAN RESOURCES

Employee Support Services | One Washington Square | San José, CA 95192-0046 408-924-2250 | 408-924-2284 (fax)

Instructions:

- *Please complete part I and return form to: Campus Privacy Contact Rick Casillo at the address above. If you have any questions you may contact Rick at (408) 924-2149.*
- *Please print or type in ink.*

You have the right to ask the Plan to restrict the use and disclosure of your health information for Treatment, Payment, or Health Care Operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or Payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does not agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency Treatment, even if the Plan has agreed to a restriction.

EMPLOYEE INFORMATION

1. Employee Name:	1b. Employee ID Number:	1c. Employee Date of Birth:
1a. Employee Health Plan ID Number:	1d. Department/College:	
2. Name of Person Whose Records you are Requesting:	3. Your Name:	
2a. Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other (please describe relationship):	3a. Your Relationship to Person in Box 2: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other (please describe relationship):	
4. Mailing Address for Records:	4a: City, State, Zip Code:	

SECTION A: REQUEST TO RESTRICT USE AND DISCLOSURE OF PERSONAL HEALTH PLAN

I request that the use and disclosure of personal health information for the person in Box 2 be restricted in the manner described below:

I understand that the Plan may deny this request. I also understand that the Plan may remove this restriction in the future if I am notified in advance.

SECTION B: REQUEST TO TERMINATE RESTRICTED USE AND DISCLOSURE OF PERSONAL HEALTH PLAN INFORMATION

☐ I request that the restriction on the use and disclosure of personal health plan information made on _____ **[Date Initial Request Made]** be terminated. I understand that upon receipt of this form, the Plan will terminate the previously accepted restriction. Once a restriction has been terminated, the Plan will use and disclose personal health plan information as permitted or required by law.

☐ I agreed orally to terminate the restricted use and disclosure of personal health plan information belonging to the person in Box 2 made on the _____ **[Date Initial Request Made]**

_____ _____

Signature Date

SAN JOSÉ STATE UNIVERSITY

PART II – DETERMINATION OF REQUEST FOR RESTRICTED USE OF PERSONAL HEALTH PLAN INFORMATION

HUMAN RESOURCES

Employee Support Services | One Washington Square | San José, CA 95192-0046 408-924-2250 | 408-924-2284 (fax)

DETERMINIATION
After reviewing your request to restrict use of personal health plan information, the Plan has made the following determination **[check one (1**)]: ☐ Request Approved ☐ Request Denied
Name of Plan Representative _____ Signature of Plan Representative _____ Date of Determination _____

SAN JOSÉ STATE UNIVERSITY

PART III – TERMINATION OF A REQUEST FOR RESTRICTED USE OF PERSONAL HEALTH PLAN INFORMATION

HUMAN RESOURCES

Employee Support Services | One Washington Square | San José, CA 95192-0046 408-924-2250 | 408-924-2284 (fax)

TERMINIATION
The Plan is providing you with notice that it is terminating its agreement to restrict its use and disclosure of personal health plan information as documented above in Part II of this Form. Any personal health plan information created or received on or after **[Date of Mailing]** will not be subject to the restriction. The Plan may use and disclose your personal health plan information as permitted by law.
Name of Plan Representative _____ Signature of Plan Representative _____ Date of Determination _____