



**Member Request to Restrict Uses  
and Disclosures of Protected Health Information**

---

**Section I: Member/Dependent Information** -All fields are mandatory and should be completed for the form to be processed timely. **Please Print Clearly & Legibly**

Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State and Zip \_\_\_\_\_

Phone \_\_\_\_\_ E-mail Address \_\_\_\_\_

---

**Section II: OSU Employee/Member Information**

Name \_\_\_\_\_

Luminare Member ID Number \_\_\_\_\_

---

**Section III: Requestor Information (complete if you are not the member)**

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State & Zip \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to Member \_\_\_\_\_

---

**Section IV: THIS SECTION MUST BE COMPLETED**

I hereby request that the following restriction(s) be placed on the uses and disclosures of my protected health information by the Ohio State University Health Plan Inc.

Benefits affected:  Medical Claim (Luminare)  Other \_\_\_\_\_

**List of Restrictions Requested**

Please give a full, specific description of the type of restrictions you are requesting regarding how and to whom your protected health information is used and disclosed. Restrictions may only be requested for those uses and disclosures that relate to your treatment, your payment or insurance, or the business operations of The Ohio State University Health Plan Inc. (For example, you may request that we restrict the use of your information for disease management purposes.)

***This form must be accompanied by signature page on the second page of this form.***



**THE OHIO STATE UNIVERSITY**

HEALTH PLAN

I understand that The Ohio State University Health Plan Inc. is not required to agree to my restriction requests, but that OSU Health Plan may only be required to attempt to accommodate reasonable requests when appropriate. I further understand that OSU Health Plan reserves the right to terminate an agreed-to restriction if it feels that termination is appropriate, and that I also have the right to terminate, in writing, any restriction by sending a termination notice to the Health Plan Privacy Officer at the address at the bottom of this form.

\_\_\_\_\_  
**Member Signature or Personal Representative Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

**If Personal Representative, source/document, such as Healthcare Power of Attorney, of authority to act for Member is required.**

**For this form to be valid, it must be filled out accurately and completely.**

Return this form to: The OSU Health Plan, Inc., 700 Ackerman Road, Suite 1007, Columbus, Ohio 43202 or fax to (614) 292-8366.

---

**FOR OSU HEALTH PLAN PRIVACY OFFICE USE:**

**APPROVED BY:** \_\_\_\_\_  
OSU Health Plan HIPAA Privacy Officer

**DATE:** \_\_\_\_\_

**REASON DENIED:** \_\_\_\_\_

**DENIED BY:** \_\_\_\_\_  
OSU Health Plan HIPAA Privacy Officer

**DATE:** \_\_\_\_\_