COMMUNITY Health Options®

Request for Restrictions on the Use or Disclosure of PHI

Members of health benefit plans have the right to request restrictions on how Community Health Options will use and/or disclose their protected health information (PHI) for treatment, payment or health care operations and how their information will be disclosed or not disclosed to family members or others involved in their care.

Community Health Options may, at its discretion, refuse to agree to restrictions on the use of PHI requested by the Member. Please return this completed form to Community Health Options' Privacy Officer at:

Community Health Options
Mail Stop 100, P.O. Box 1121
Lewiston, ME 04243

Member Name	Member Identification Number	Date of Birth

I request that Community Health Options not use and/or disclose my health information for treatment, payment, or health care operations to the following parties and/or for the following reasons:

_____

_____

_____

_____

I request that Community Health Options not disclose my health information to the following person(s):

_____

_____

_____

_____

Please list the reason(s) for the above request(s):

_____

_____

_____

_____

I understand that Community Health Options is not required to grant my restrictions request.

Signature:_____ Date: _____