Request to Restrict Protected Health Information (PHI)

Highmark Blue Cross Blue Shield, Highmark Blue Shield & Affiliated Health Plans**

Please return completed form to:
Highmark, Inc
Privacy Operations
120 Fifth Avenue Place, Suite 2114
Pittsburgh, PA 15222

Please complete all fields. If information is missing, we will return the form to you for completion. If you need help with this form, contact the Customer Service number listed on your member identification card.

MEMBER INFORMATION - (Please PRINT the information for the member whose PHI you want to restrict.)		
Member Name:		Date of Birth:
Address:		
City:	State:	Zip:
Phone:		Member ID:

RESTRICTION REQUESTED
Describe the protected health information or records you would like to restrict.
State how you would like to restrict the information described above.
List any person(s) or organization(s) to be restricted from future uses or disclosures of the information.

I request that Highmark and its subsidiaries and affiliates (Highmark) restrict the use and disclosure of my protected health information (PHI) for treatment, payment, health plan operations, or to other persons involved in my care. I understand that if my request is granted, Highmark may, in spite of the restriction:

- Use or disclose the restricted information in an emergency situation for treatment purposes;
- Use or disclose the restricted information pursuant to my written authorization;
- Use or disclose the restricted information as required by law.

Signature of Member or Legal Representative*	Date
Printed name of Member or Personal Representative	Relationship to Member

***If you are signing this form as a legal representative for the member, you must attach copies of your authorization as required by state law to represent the member (e.g., healthcare power of attorney, healthcare surrogate, or guardianship papers).**

Disclosures:

Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association:

Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life, Highmark Senior Health Company, Highmark Care Benefits Inc., or Gateway Health Plan, Inc. d/b/a Highmark Wholecare.

Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company, Highmark Senior Health Company, or Gateway Health Plan, Inc. d/b/a Highmark Wholecare.

PA: Your plan may not cover all your health care expenses. Read your plan materials carefully to determine which health care services are covered. For more information, call the number on the back of your member ID card or, if not a member, call 866-459-4418.

Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield or Highmark BCBSD Health Options Inc. d/b/a Highmark Health Options.

West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company, Highmark Senior Solutions Company, or Highmark Health Options West Virginia Inc. d/b/a Highmark Health Options and Highmark Blue Cross Blue Shield. Visit https://www.highmarkbcbswv.com/networkaccessplan to view the Access Plan required by the Health Benefit Plan Network Access and Adequacy Act. You may also request a copy by contacting us at the number on the back of your ID card.

Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield.

Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.