



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):

CONFIDENTIALITY NOTICE: This communication was reviewed for compliance with applicable privacy standards prior to distribution. All parties sending, handling, or storing protected health information are obliged to meet relevant HIPAA standards. This communication is intended only for the use of the individual to which it is addressed. If you have received this communication in error, please notify us immediately at (855) 624-6463. This communication and its information may be protected by federal and/or state privacy and confidentiality rules. You are hereby notified that any disclosure, dissemination, or copying of this communication or its information is prohibited unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law.



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: _____

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