RESTRICTION OF PROTECTED HEALTH INFORMATION REQUEST FORM

Use this form to request that Start restrict the use or disclosure of your Protected Health Information (PHI) for treatment, payment, or health care operations purposes. You may also request that Start only disclose your PHI to a family member, relative, or others involved in your care. You may do many of these functions through our member portal. This form can be used to terminate a previously granted request for restriction. You must complete all the fields on this form. If you need assistance completing this form, contact our Personal Health Assistants (PHAs) at 800-894-9454. We are not required to agree to all restrictions and will consider them on a case by case basis.

When completed and signed please mail to: Start Health
P.O. Box 7009718
Sandy, UT 84070
You may also email this form to support@starthealth.com

Section I. Restriction Request or Termination:	
Is this form being used to terminate a previously approved request for Restriction? If "Yes", complete Section II, then proceed to Section IV. If "No", then complete the form entirely.	
☐**Yes**- Enter date to terminate previous request:	Date: month/day/year
☐**No**	

Section II: The Member that restricted PHI is being requested for:			
Member Name	Group #	Member ID #	
Social Security Number	Date of Birth		
Address	City	State	ZIP
Area Code & Telephone Number			

Section III. Please tell us what PHI you want restricted:
Please tell us how you would like to restrict the use and disclosure of this information:

Before we grant your request, you need to be aware of the following:

1. The request only applies to your current coverage. If any of the information about your coverage changes including Group or Member number, benefit coverage changes, you must submit a new Restriction Request.

2. The request will expire eighteen (18) months after your benefits coverage has terminated.
3. Start and its Business Associates are only responsible for restricting the PHI that you tell us about in Section III.

Section IV. Signature- This document must be signed by the Member, parent of minor child or the Member's Personal Representative.	
I request that Start restrict the use of disclosure of my PHI as specified in Section III above. I understand that Start is under no obligation to agree to my request. I understand I will receive a written determination regarding my request. I understand that if I'm signing on behalf of a minor child, this request will expire upon the child reaching the age of eighteen (18).	
Signature	Date: month/day/year

Section V. If Section IV is signed by a Personal Representative, please complete the information below.	
If you are signing as a Power of Attorney, Legal Guardian, Executor, or Administrator, please attach a copy of the legal documents.	
Personal Representative's Name	Relationship to Member
Personal Representative's Address	City
Personal Representative's Phone Number	Representative's Email

Any changes to the form must be approved by the privacy officer.
support@starthealth.com