HUMBOLDT INDEPENDENT PRACTICE ASSOCIATION
2662 HARRIS STREET, EUREKA, CA 95503-4856
PHONE: (707) 443-4563 FAX: (707) 443-2527
www.humboldtipa.com

REQUEST TO RESTRICT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use this form to restrict how Humboldt IPA uses and/or discloses your protected health information (PHI). When filling out this form, please complete all sections, print information clearly and provide your most current information. Once the decision to grant or deny your request has been made, you or your authorized representative will receive a letter notifying you of the decision.

Member information (please provide current information)

Last Name:	**First Name:**	**MI:**
Mailing Address:		
City:	**State:**	**ZIP:**
Date of Birth:	**Gender:**	**Phone Number:**

Specific restriction requested

Please state how you would like Humboldt IPA to restrict the ways we use and/or disclose your PHI and the reason(s) for your request.

Member/authorized representative signature

Authorized signature of individual—or personal representative of individual—for whom the restriction is being requested:

X____ _____________________
Member Signature Date

X____ _____________________
Authorized Representative Signature (if applicable) Date

Important: If legal documentation is not on file with Humboldt IPA, the authorized representative, including the parent, legal guardian, or executor of an estate, must attach a copy of legal documentation to this form.

Authorized Representative's Name:		**Phone Number:**
Mailing Address:		
City:	**State:**	**ZIP:**
Relationship to Member and Authority to Act for Member:		

Please mail the completed form to:

Humboldt IPA
Privacy Officer
2662 Harris Street
Eureka, CA 95503

or fax to1-707-443-2527