



**Restriction Request Form**  
**For Use and Disclosure of Protected Health Information (PHI)**

**Complete and send this form to:**

**Privacy Officer**

**UHH Alaska Plan**

1901 Las Vegas Blvd. S., Ste 107

Las Vegas, Nevada 89104-1309

**Phone:** 844-427-8501

**Fax:** 702-216-0885

**Email:** AlaskaPlan@Zenith-American.com

*(Please note, if you email personal information to UHH Alaska Plan, we can't ensure it's secure or private until it's received.)*

**Participant Name** \_\_\_\_\_

**Participant SS#** \_\_\_\_\_

**Requested Restrictions**

**Patient Information** - This is the person for whom Protected Health Information is to be restricted.

Patient's Name	Date of Birth (month-day-year)	SS#	Relationship to Participant	
Street	City	State	Zip	( ) Telephone

In completing this form, you are requesting the following restrictions be considered as limitations to the UNITE HERE HEALTH's use and disclosure of your health information. If your request is approved, we are bound by the terms of the agreement, until such time as the restriction may be terminated, either by you or UNITE HERE HEALTH. You will be notified in writing of UNITE HERE HEALTH's decision to accept or deny your restriction request. Until a decision is reached, your request for restriction will not be effective.

**Do not release information regarding:**

- Any medical diagnosis/treatment
- A specific diagnosis - state diagnosis here: \_\_\_\_\_
- Treatment between these dates: \_\_\_\_\_ and \_\_\_\_\_
- Other - explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Do not release information to:**

- Name of the person you do not want to have access: \_\_\_\_\_  
Relationship: \_\_\_\_\_
- Anyone other than myself

Reason request is being made: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Patient (parent or guardian if the patient is a minor) or Personal Representative \_\_\_\_\_ Date (month-day-year) \_\_\_\_\_

Printed Name \_\_\_\_\_ Phone Number Where We May Contact You \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**For UNITE HERE HEALTH Use Only**

<input type="checkbox"/> Accepted	<input type="checkbox"/> Denied
Privacy Officer Signature: _____	Date Received: _____
Dept. Manager Signature: _____	Date: _____