Restriction request

Member information (please print)

This section must be completed with the information specific to the individual. A contact number or address is needed in case additional information or clarification is required.

Date: _____ **Member ID:** _____

Name: _____ **Date of birth:** _____

Address: _____ **Telephone:** _____

_____ **Email:** _____

You have the right to request that Davis Vision restrict the use or disclosure of your protected health information for treatment, payment or health care operations or to persons involved in your care or payment for that care. Davis Vision is under no obligation to agree to your request. If Davis Vision does, the agreement must be in writing and Davis Vision will then restrict the use or disclosure of your protected health information as you request. Davis Vision may, notwithstanding the agreement, use or disclose the restricted information needed for your treatment in an appropriate medical emergency, or when the use or disclosure without your written permission is authorized or required by law. You may end the restriction at any time by notifying Davis Vision in writing. Davis Vision may end the agreement to restrict use or disclosure of your protected health information at any time by notifying you in writing. If you agree with the decision to end the restriction, your protected health information will no longer be subject to the restriction. If you disagree, the termination of the restriction will apply only to your protected health information that Davis Vision creates or receives after giving you notice that we are terminating the restriction. To exercise your right to request restriction on Davis Vision's use or disclosure of your protected health information, please complete this form, sign and submit to:

Davis Vision – Privacy Office
P.O. Box 1416
Latham, New York 12110-1416
Fax: 1 (866) 999-4640

If you have questions, need additional information or assistance in completing your request, please contact the Davis Vision Privacy Office at 1 (800) 571-3366 or the address shown above.

Please specify the protected health information, the use or disclosure of which you want to restrict:

_____

_____

_____

Please state the restriction you want to apply to that protected health information:

_____

_____

_____

Signature (person requesting restriction): _____

Date: _____

If this form is signed by a personal representative on behalf of the individual, complete the following:

Personal representative's name (please print): _____

Description of personal representative's authority: _____

Note: Please retain a copy of this request for confidential communications for your records.