Request for Limitations and Restrictions of Protected Health Information

PARTICIPANT PLEASE NOTE: AMERIHEALTH ADMINISTRATORS IS NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS.

Participant Name: _____ Date of Birth: _____

Participant Address: _____
Street Apartment # City, State Zip

Type of PHI to be restricted or limited: _____

_____

_____

_____

_____

_____

How would you like your PHI restricted? _____

_____

_____ _____
Signature of Participant or Legal Guardian Date

FOR INTERNAL USE ONLY:

Date Request Received _____

To: _____
_____
_____

Enclosed is the form you have requested. Please complete and return all pages of the form to our attention:

AmeriHealth Administrators
Attn: Privacy Official
1900 Market Street, Suite 500
Philadelphia, PA 19103

- Only fully completed forms will be accepted.
- Forms must be typed or legibly written.
- Forms must be signed and dated.

We will begin to process your request on the day it is received. If your request is denied for any reason, you will receive an explanation of the denial.