



Missouri Consolidated Health Care Plan

Request for Restriction on Use & Disclosure of Health Care Information and/or Confidential Communication

State Members

Submit this form

☐ **Online:** Upload through myMCHCP

☐ **Fax:** 866-346-8785

☒ **Mail:** PO Box 104355

Jefferson City, MO 65110-4355

ST RUD

Revised 04/2024

Instructions

If you need assistance in completing this form, please contact MCHCP at 800-487-0771.

Section 1: Member Information

Name (Last, First, MI):

☐ New Name

Address:

☐ New Address

City:

State:

Zip Code:

MCHCP ID:

OR

Social Security Number:

Primary Phone: ☐ Home ☐ Work ☐ Cell

() -

Secondary Phone: ☐ Home ☐ Work ☐ Cell

() -

Section 2: Information Restriction and Confidential Communication

Please fill out Column A **and/or** Column B:

Column A	Column B
Health Care Information to be Restricted (Please specify what information should be restricted):	Health Care Information to be Communicated Confidentially:
Nature of Restriction (Please specify to whom the information should be restricted. Ex - health plan vendor, medical provider, relative, etc.):	Preferred Alternative Location/Address/Telephone Number/Email:

Section 3: Subscriber Authorization

You have the right to request that we restrict our use and disclosure of your health care records and information. We do not have to agree to your requested restrictions. If we do agree to the requested restriction, we will abide by the restriction unless an emergency requires otherwise. You also have the right to request that we communicate certain health care information to you in confidence. We will accommodate your reasonable written requests to receive communications of health information by alternative means or at alternative locations only if you specify the alternative location, address, or telephone number and/or the alternative means of contact

Signature of Member:

Date (MM/DD/YYYY):

Or, Signature of Person Authorized by Law to Act for the Member (Attach proof of authority to act):

Date (MM/DD/YYYY):

MCHCP STAFF ONLY

Reason for Restriction: ☐ Accepted

☐ Denied

Request to Communicate Confidentially:

☐ Accepted

☐ Denied

This Request for Restriction and/or Confidential Communication Form is to be made a part of the medical record of (Member Name):

Return a copy of completed form to individual and place original as part of individual's medical record.

MCHCP 832 Weathered Rock Court Jefferson City, MO 65101 573-751-0771 800-487-0771 www.mchcp.org

Member Services Phone Hours: 8:30 a.m.-12 p.m. & 1-4:30 p.m., Monday-Friday (except State and Federal holidays)