

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

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Revised 04/2024

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

Section 1: Member In	formation				
Name (Last, First, MI):	New Name			MCHCP ID:	_
Address:	New Address			Social Security Number:	
City:		State:	Zip Code:	Primary Phone:	- Home Work Cell
				() Secondary Phone:	–
				()	

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):	1	
Or, Signature of Person A	uthorized by Law to A	Date (MM/DD/YYYY):				
				/	/	_
MCHCP STAFF ONLY						
Reason for Restriciton:	□ Accepted	Denied	Request to Communicate Confidentially:	□ Accepted	Denied	
This Request for Restriction	on and/or Confidentia	al Communication Fo	rm is to be made a part of the medical record o	f (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)