



This is the form you requested to Restrict the Use and Disclosure of Protected Health Information

This is the form that you asked Community Care to send to you.

You need to fill out this form sign your name, write the date on the form, and mail it to the address below.

**Community Care Behavioral Health Organization
Privacy Officer
One Chatham Center, Suite 700
Pittsburgh, PA 15219**

Please remember Community Care does not maintain medical records. You must contact your doctor or the hospital where you were treated for your medical records.

Community Care will review the information, and will send you a written response.

Please print and use a pen to fill in the form.

Your Name:			
Your Address:			
Your Date of Birth:		Your Social Security Number:	
Your Phone Number:		Please write down your phone number in case we need to call you.	
If you do not want this request to restrict information to expire, leave this section blank. If you do want it to stop on a certain date write the date here:			

1. Please write down on the lines below what information you would like Community Care to restrict:

2. Please enter on the line below when you would like Community Care to start restricting the use and disclosure of your information:

3. You need to sign your name and write the date on the lines below:

Member Signature: _____ Date: _____

4. If you are a minor, please write in who your guardian is:

Name: _____ Relationship: _____

Address: _____

If you have any questions about this form, please call the Member Services Number at 1-800-553-7499.

Please do not write on these lines.
Date Received: _____ **Date Reviewed:** _____ **Response Sent:** _____