WISCONSIN MEDICAID
HIPAA PRIVACY RESTRICTION REQUEST

The Privacy Rule standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) P.L. 104-191 require DHS, as a covered entity, to implement processes that give member certain rights regarding individually identifiable health information. The information requested on this form is needed to comply with those Privacy Rule requirements.

Provision of the information that is requested on this form is voluntary. Although the use of this version of the form is voluntary, all of the information outlined on this form is mandatory.

Personally identifiable information requested on this form is mandatory in order to process your request and will only be used for this purpose.

INSTRUCTIONS: Mail this completed form to the following address:

Wisconsin Medicaid
Member Services
PO Box 6678
Madison WI 53716-0678

SECTION I — MEMBER INFORMATION

Name — Last, First, Middle Initial	Wisconsin Medicaid Identification Number
Address — Street, City, State, ZIP Code	Telephone Number ( )

SECTION II — RESTRICTION POLICY SUMMARY AND REQUEST

To exercise your right to request restrictions of the DHCAA to use or disclose your protected health information, read the following and complete this form.

You have the right to request that the Wisconsin Division of Health Care Access and Accountability (DHCAA) restrict the use or disclosure of your protected health information. The DHCAA is under no obligation to agree to your request. If the DHCAA does agree with your restriction request, our agreement will be in writing and the DHCAA will then restrict the use or disclosure of your protected health information per your request. The DHCAA may still use or disclose the restricted information when you authorize us in writing to use or disclose the information, or when the law requires the use or disclosure.

You may end the restriction at any time by notifying us in writing. The DHCAA may also end the agreement to restrict use or disclosure of your protected health information at any time by notifying you in writing. The termination of the restriction will apply only to your protected health information received after the DHCAA has mailed you a letter agreeing to the termination of the restriction.

Specify the protected health information you want to restrict:_____

_____

_____

State the restriction you want to apply to that protected health information:_____

_____

_____

Continued

SECTION III — SIGNATURES

Please sign the form and complete the appropriate information.

SIGNATURE — Member	Date Signed

If this request is from a personal representative on behalf of the member, provide a copy of the documentation to support the representation and complete the following:

Name — Personal Representative	Relationship to member
SIGNATURE — Personal Representative	Date Signed

RESET FORM