DRUGSOURCE, INC.

# Restriction Request Form

Use this form to request restrictions on DrugSource, Inc.'s use or disclosure of your Protected Health Information (PHI) for treatment or payment purposes. You may also use this form to terminate a previously granted request for restriction.

**PLEASE NOTE: THIS FORM IS NOT A PROFILE FORM.**
**If you need assistance in completing this form, or with any other changes to your patient profile, please call Customer Service at 800/854-8764.**

**WHEN COMPLETED AND SIGNED, PLEASE MAIL TO:**

**DRUGSOURCE, INC.**
**PO Box 1366**
**Elk Grove Village, IL 60009-1366**

## Section A: Restriction Request or Termination

Is this form being use to terminate a previously approved request for Restriction? If "Yes", complete Section B, then proceed to Section D. If "No", complete the form in its entirety.

☐ **Yes** – Enter date to terminate previous request: _____
**Date: Month/Day/Year**

☐ **No**

## Section B: The individual for whom restriction is being requested. Please complete the following:

_____ _____ _____
Name of Individual | Group # | ID#

_____ _____
Date of Birth | Cardholder Name

_____ _____ _____
Address | City | State | Zip Code

_____ _____
Area Code & Telephone Number | E-mail address (If Available)

## Section C: Please specify the Protected Health Information (PHI) you want restricted:

_____

_____

_____

**Please state how you would like to restrict the use and disclosure of this information:**

_____

_____

_____

# DRUGSOURCE, INC.

**If this request is granted, please note the following:**

1. **If your insurance coverage changes, you must submit a new Restriction Request with the new insurance information (Plan Name, ID number & Group Number).**
2. **This request will expire two (2) years after your plan has terminated with DrugSource, Inc.**
3. **DrugSource, Inc. and its business associates are only responsible for the PHI that they release in accordance with your designation in Section C.**

**Section D: Signature – This document must be signed by the individual, parent of minor child or the individual's Personal Representative.**

I request that DrugSource, Inc. restrict the use or disclosure of my PHI as specified in Section C above. I understand that DrugSource, Inc. is under no obligation to agree to my request. I understand I will receive a written determination regarding my request. I understand that if I am signing on behalf of a minor child, this request will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____ _____

**Signature** **Date: Month/Day/Year**

**Section E: If Section D is signed by a Personal Representative, please complete the following information:**

If you are signing as Legal Guardian, Power of Attorney, Administrator or Executor, attach a copy of the Legal documents. You do **NOT** have to attach these copies if these documents are already on file with DrugSource, Inc.

_____ _____

**Personal Representative's Name** **Relationship to Individual**

_____ _____ _____ _____

**Personal Representative's Address** **City** **State** **Zip Code**

_____ _____

**Personal Representative's Area Code & Telephone Number** **Personal Representative's E-Mail Address (if available)**

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**For Office Use Only**

This request has been:

☐ **Approved**

☐ **Denied**

_____

**DrugSource, Inc. Representative**

_____

**Date Filed**