Pacific Gas and Electric Company

Request for Restricted Use of Personal Health Plan Information

Form Received By	Date

You have the right to ask The Pacific Gas and Electric Company Health Care Plan for Active Employees, The Pacific Gas and Electric Company Health Care Plan for Retirees and Surviving Dependents, and Pacific Gas and Electric Company Health Care Flexible Spending Account Plan (collectively, “Health Plan”) to restrict the use and disclosure of your protected health information (PHI) for Treatment, Payment, or Health Care Operations, except for uses or disclosures required by law. You have the right to ask the Health Plan to restrict the use and disclosure of your PHI to family members, close friends, or other persons you identify as being involved in your care or Payment for your care. You also have the right to ask the Health Plan to restrict use and disclosure of PHI to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Health Plan must be in writing.

The Health Plan is not required to agree to a requested restriction. If the Health Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Health Plan (including an oral agreement), or unilaterally by the Health Plan for PHI created or received after you’re notified that the Health Plan has removed the restrictions. The Health Plan may also disclose your PHI if you need emergency Treatment, even if the Health Plan has agreed to a restriction.

1. Employee/Retiree Name	**1a. Employee/Retiree PERNO**
1b. Employee/Retiree Date of Birth	
2. Name of Person Whose Records You Are Requesting	**2a. Relationship to Employee** ☐ Self ☐ Spouse ☐ Child ☐ Other
3. Your Name	**3a. Your Relationship to Person in Box 2** ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ **Other (please describe relationship):**
4. Mailing Address for Records	**4a. City, State, Zip Code**

Section A: Request to Restrict Use and Disclosure of Personal Health Plan Information

I request that the use and disclosure of PHI in personal health plan information for the person in Box 2 be restricted in the manner described below:

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☐ I have / ☐ I have not : already paid the health care provider in full for the items or services related to this information.

I understand that the Health Plan may deny this request. I also understand that the Health Plan may remove this restriction in the future if I am notified in advance.

Section B: Request to Terminate Restricted Use and Disclosure of Personal Health Plan Information

☐ I request that the restriction on the use and disclosure of PHI in personal health plan information made on ________________________ **[Date Initial Request Made]** be terminated. I understand that upon receipt of this form, the Health Plan will terminate the previously accepted restriction. Once a restriction has been terminated, the Health Plan will use and disclose PHI as permitted or required by law.

☐ I agreed orally to terminate the restricted use and disclosure of PHI in personal health plan information belonging to the person in Box 2 made on ________________________ **[Date Initial Request Made]**. This serves as formal documentation of that oral agreement.

____ ______________________

Signature **Date**

Please return completed form to:
PG&E HIPAA Administrator, PG&E Benefits Department, 245 Market Street, Mailcode N2T, San Francisco, CA 94105