

INDIVIDUAL REQUEST NOT TO USE OR DISCLOSE HEALTH INFORMATION

I understand that the _____ Health Plan may use and disclose protected health information about me for purposes of health care treatment, payment and health care operations without my consent. I request to restrict use and disclosure of protected health information concerning health care treatment, payment or health care operations about me by the _____ Health Plan in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Group Health Plan Not Required To Agree

I understand that the group health plan is not required to agree to this restriction.

Termination of Restriction

I understand that if the group health plan agrees to this restriction, either the Plan or I may terminate this restriction at any time. The termination of the restriction is only effective for future uses and disclosures.

Emergency Treatment Exception

I understand that if protected health information must be used or disclosed to provide emergency treatment for me, then this restriction is void.

Questionnaire

Requestor: Please complete all of the following questions. If the question is not applicable, mark N/A on the answer line.

- (1) I request the following information be restricted:

- (2) I request that use and disclosure of the above described information be restricted in the following manner:

- (3) I request that my protected health information not be disclosed to the following individuals or entities:

I understand that if a restriction is not specifically listed above and agreed to in writing by the group health plan, it will not be effective.

Signature _____ Date _____