INDIVIDUAL REQUEST NOT TO USE OR DISCLOSE HEALTH INFORMATION

NAME OF PLAN:

TO: PLAN SPONSOR PRIVACY OFFICER

I understand that the above group 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 above 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 [description of information]:

____

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

____

(3) I request that my protected health information not be disclosed to the following individuals or entities [list individuals or entities to which information would not be disclosed]:

____

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: ____