REQUEST FOR RESTRICTIONS ON USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Participant Name:_________________________________ Social Security Number: ____________________

Address: ____

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Home Telephone Number: _____________________ Work Telephone Number: ________________________

E-mail Address: ____________________________ Participant Birth Date: ___________________________

I am requesting a restriction on the MPI Health Plan's use and/or disclosure of my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) in the manner described below. I understand that the MPI Health Plan may deny this request for any reason. I also understand that if agreed to, the MPI Health Plan may not be able to honor this request if I require emergency treatment and that the MPI Health Plan may remove this restriction in the future, if I am notified in advance.

Description of Restriction of the Health Information to be Used or Disclosed. The following is a description of the specific health information I wish to restrict:

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Persons/Organizations Restricted from Use and/or Disclosure of Health Information. I request that the following person(s) and/or organization(s) not be allowed to use, receive and/or disclose the health information described above.

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By signing this form, I am confirming that it accurately reflects my wishes.

____ ____/____/____

Participant Signature *Date*

If this Request for Restrictions is to be signed by a personal representative, that personal representative must also sign below before submitting this form to the MPI Health Plan.

If signed by personal representative, name of personal representative: ______________________________

Relationship to Participant or nature of authority:____

____ ____/____/____

Signature of Personal Representative *Date*

THIS REQUEST MUST BE COMPLETED IN FULL BEFORE BEING SUBMITTED