RESTRICTION REQUEST

Use this form to request a restriction of our use and disclosure of your protected health information (PHI) that we, or our business associates, maintain for treatment, payment or health care operations, to persons involved in your care, or payment for that care.

Please complete the following:

NAME			DAYTIME PHONE NUMBER
ADDRESS			
CITY	STATE	ZIP	CONTRACT NUMBER

Please read and complete the following:

You have the right to request that we restrict our use and disclosure of your PHI for treatment, payment and health care operations to persons involved in your care, or payment for that care. We are not required to grant your request. If we do, our agreement will be in writing and we will restrict our use and disclosure of your PHI as you request. We may, however, use and disclose the restricted information in appropriate medical emergency situations, or when use or disclosure without your written permission is authorized or required by law.

You can terminate the restriction at any time by notifying us in writing. We can also terminate our agreement to a restriction at any time by notifying you in writing. If we do, termination is effective only to PHI that we create or receive after we gave you our written notice terminating the restriction.

To exercise your right to request a restriction on our use and disclosure of your PHI, please specify the PHI you want to be handled in a restricted fashion, and the restrictions you want us to apply:

Does this request include PHI related to services rendered at a BCN Health Center? Yes ☐ No ☐

Please sign and date:

I request that you restrict the use and disclosure of my PHI as specified above. I understand that you are not required to agree to my request, (but if you do, you will inform me of any termination of the restriction in writing).

____ _______________________________

Signature Date

If you are not the member, please sign and write today's date below, then check the box that describes your relationship to the member. If you are not the parent of the member, please attach proof of your relationship to the member.

Please Print Name of Personal Representative: ____

____ _______________________________

Signature of Personal Representative Date

☐Parent ☐Legal Guardian ☐Power of Attorney ☐Executor ☐Other _________________________

Please mail to:

Individual Rights Unit, M.C. 2004
BCBSM/BCN – P.O. Box 2459
Detroit, MI 48231-2459

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