

Individual Request for Restriction

PURPOSE: This form is used for an individual's request to restrict use or disclosure of protected health information, including for treatment, payment or health care operations.

SECTION A: Individual Requesting Restriction

Covered Employee's Name: _____ Employee's SSN: _____ - _____ - _____

Covered Employee's Employer: _____ Current Phone: _____ - _____ - _____

Name of Individual Making Request: _____ Individual's SSN: _____ - _____ - _____

Current Address: _____

SECTION B: To the Individual – Please read the following and complete the information requested.

You have the right to request that CenBen USA, Inc. restrict our use or disclosure of your protected health information, including for treatment, payment or our health care operations. **We are under no obligation to agree to your request.** If we do, our agreement must be in writing and we will then restrict our use or disclosure of your protected health information as you request. We may, notwithstanding our agreement, use or disclose the restricted information in an appropriate medical emergency when the information is needed for your treatment, or when you authorize us in writing to use or disclose the information, or when the use or disclosure is required by law.

You may end the restriction at any time by notifying us in writing. We may end our agreement to restrict use or disclosure of your protected health information at any time by notifying you in writing. If you agree with our decision to end the restriction, your protected health information will no longer be subject to the restriction. If you disagree, our termination of the restriction will apply only to your protected health information that we receive after we gave you our notice terminating the restriction. To exercise your right to request restriction on our use or disclosure of your protected health information, please complete this Section B.

Please specify the protected health information, the use or disclosure of which you want to restrict:

Please state the restriction you want to apply to that protected health information:

Please state the reason you are requesting this restriction:

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SECTION C: Signatures

I request CenBen USA, Inc. to restrict the use or disclosure of my protected health information as specified in Section B above. I understand that CenBen USA, Inc. is under no obligation to agree to my request, and that there will be no agreement unless CenBen USA, Inc. informs me in writing that it agrees to my request.

Patient's Printed Name

Date

Patient's Signature

Date

If this request is signed by a personal representative on behalf of the individual, complete the following:

Patient Representative's Printed Name

Date

Patient Representative's Signature

Date

Relationship of Representative to Individual

Please submit this request to HealthSCOPE Benefits at any of the following addresses:

HIPAA Official
P.O. Box 1224
Little Rock, AR 72203
or

Customer Service – HIPAA
PO Box 16526
Columbus, Ohio 43216
or

Customer Service – HIPAA
PO Box 50440
Indianapolis, IN 46250

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM