

## Request For Restrictions On Use and/or Disclosure Of Protected Health Information

Participant Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home Telephone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Participant Social Security Number: \_\_\_\_\_

I, \_\_\_\_\_, am requesting a restriction on the San Francisco Electrical Workers Health & Welfare Plan's (Health Plan) 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 Health Plan may deny this request for any reason. I also understand that if agreed to, the Health Plan may not be able to honor this request if I require emergency treatment and that the 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:

\_\_\_\_\_  
\_\_\_\_\_

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:

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
Signature Date

**If signed by personal representative:**

Name of personal representative: \_\_\_\_\_

Relationship to participant or nature of authority: \_\_\_\_\_

\_\_\_\_\_  
Signature of Personal Representative Date

**Submit Form to: Privacy Official, 720 Market St., Suite 700, San Francisco, CA 94102**