



## APWU Health Plan Request for Restriction

With this form you may request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend.

**Please print neatly to ensure accurate processing and to avoid delays in service.**

### 1. Member Information:

Member's ID #: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Member's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Work Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Policy Holder's ID#: \_\_\_\_\_

### 2. To the individual – Please read the following and complete the information requested

You have the right to request that the APWU Health Plan restrict our use or disclosure of your protected health information, including that used for treatment, payment, or health care operations. This includes protected health information used by our Business Associates. We will then restrict our use or disclosure of your protected health information as you request, except that we may use or disclose the restricted information in a medical emergency if it's 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 or authorized by law.

Please note that the APWU Health Plan is not obligated to honor your request for restriction but will notify you in writing of our decision within sixty (60) days of receipt of your request.

You may end this restriction at any time by notifying the APWU Health Plan in writing. We may terminate our agreement to restrict the use or disclosure of your protected health information at any time by notifying you in advance in writing.

Please specify the protected health information you would like restricted (be as specific as possible):

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\_\_\_\_\_

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Please specify how you would like the protected health information restricted (be as specific as possible):

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Please specify which individuals and/or companies you would like the restriction to apply to:

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**3. Signature:**

I request the APWU Health Plan to restrict the use or disclosure of my protected health information as specified above. I understand that I will receive a response to my request for restriction in writing within sixty (60) days from the date the APWU Health Plan receives it and that the restriction will not become effective until I receive a response that the APWU Health Plan has agreed to honor my request. I understand that I may terminate this restriction at any time by notifying the APWU Health Plan in writing and that the APWU Health Plan may also terminate this restriction at any time by notifying me in writing.

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

Print Name: \_\_\_\_\_

If this request is being made by a Personal Representative on behalf of the Member, complete the following:

Personal Representative's Name: \_\_\_\_\_

The APWU Health Plan has a copy of the Personal Representative form on file.

Attached is a copy of the Personal Representative form.

**Please mail this Request for Restriction to:**

APWU Health Plan  
Privacy Specialist  
799 Cromwell Park Drive, Suites K-Z  
Glen Burnie, MD 21061  
1-800-222-2798

**Please keep a copy of this Request for Restriction for your records.  
We will provide you with a signed copy of this Request for Restriction at your request.**