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 may also use this form 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. Requestor Information:

Requestor ID #: _____

First Name: _____ MI: _____

Last Name: _____ Date of Birth: ____ / ____ / ____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ____ - ____ - ____ Work Phone: _____ - _____ - _____

E-mail Address: _____

2. Please read the following and complete the information requested

You may 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. We may 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, 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 writing.

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

_____

_____

_____

_____

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

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

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 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:** _____

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
HIPAA Privacy/Security 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.