

MEBS, INC.
REQUEST FOR RESTRICTION OF
PROTECTED HEALTH INFORMATION (PHI)

Participant Name: _____ DOB: ___/___/___
MM / DD / YR

Social Security Number: _____

Employer: Name: _____

I am requesting a restriction on MEBS' 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 MEBS may deny this request for any reason. I also understand that if agreed to, MEBS may not be able to honor this request if I require emergency treatment and that MEBS 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: _____