Request for Restrictions on Use and Disclosure of Health Information

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this request for restriction in whole or in part, but if we do, we are bound by our agreement. Any restriction we accept will not apply when the restricted information is needed to provide you with emergency treatment. This agreement does not apply if release is required by law or if it's against any public health requirements. We further have the right to terminate any agreed upon restriction by informing you of the termination in writing. Any such termination will only apply to information created or received after we have informed you of the termination.

Please complete this form to request a restriction and return it to UPCAP Services, c/o Mary Ross, P.O.Box 606, Escanaba, MI 49829. We will notify you of our ability to comply with your request by returning a copy of this form to you. You also have the right to request us to terminate a restriction to the extent that such termination applies to information created or received after the date of termination.

INDIVIDUAL'S INFORMATION

Name:	Request Date:
Contact Phone Number(s):	Birthdate:
Current Address (No., Street, P.O. Box, City, State, Zip):	

RESTRICTIONS REQUESTED

1. I would like use and disclosure of the following health information to be restricted:

2. I want the information restricted because:

Check the box that tells how you want this information to be restricted and complete section:

☐ I do not want this information to be given to the following person(s) or agency(s):

☐ Other restrictions requested:

ACKNOWLEDGEMENT-Please sign and date:

Name _____ Signature _____ Date _____

If you are not the participant, please complete, sign and date below. Check the box that describes your relationship to the participant. Please attach proof of your relationship to the participant (e.g. power of attorney, legal guardian).

Name _____ Signature _____ Date _____

☐ **Personal Representative** ☐ **Legal Guardian** ☐ **Power of Attorney** ☐ **Executor** ☐ **Other:** _____

This Section for Company Use Only

Request has been: ☐ **Accepted** ☐ **Denied (if denied, check the reason for denial):**

- ☐ **Treatment, payment or healthcare operations**
- ☐ **Legal requirements**
- ☐ **Emergencies**
- ☐ **Financial obligations**

Comments:

Restriction Request has been reviewed by:

Date	Please print name	Signature
Date	Please print name	Signature

Notification was sent to the participant: _____
Date

Send a copy of completed form to individual. Send original to Support Corrdinator to place in Participant's chart.

Date copy sent: _____ *Copy sent by (print name):* _____