

SEAFARERS HEALTH AND BENEFITS PLAN

5201 Auth Way

Camp Springs, Maryland 20746

1 (800) 252-4674

Request For Restrictions On Use and Disclosure Of Protected Health Information

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

Address: _____

Daytime Phone Number: _____
Evening Phone Number: _____ Social Security Number: _____

I am requesting a restriction on the use and/or disclosure of the following protected health information:

I am requesting that the use and/or disclosure of this protected health information be restricted in the following manner:

I am requesting that this protected health information not be disclosed to the following person(s) and/or organization(s):

I understand that the Plan may deny this request. I also understand that even if the Plan agrees to this request the Plan may remove this restriction at some future time, but only if I am notified in advance. I further understand that if I require emergency treatment it may be necessary for the Plan to remove this restriction.

Signature of Participant: _____ Date ____/____/____

If signed by personal representative:

Name of personal representative: _____

Relationship to participant or nature of authority: _____

Signature of Personal Representative _____ /____/____
Date