

# ***SEAFARERS HEALTH AND BENEFITS PLAN***

5201 Capital Gateway Drive  
Camp Springs, Maryland 20746-4275  
(301) 899-0675

Margaret R. Bowen  
Administrator

## **REQUEST FOR RESTRICTIONS ON USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

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

Social Security # \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_ Evening Phone 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