Individual Request Not to Use or Disclose (Restrict) Health Information or to End Restriction on Use or Disclosure of Health Information Maintained

I understand that Arkansas Blue Cross and Blue Shield may use and disclose protected health information about me for purposes of health care treatment, payment, and health care operations without my consent. I request to restrict use and disclosure of protected health information concerning health care treatment, payment, or health care operations about me by Arkansas Blue Cross and Blue Shield in accordance with the Health Insurance Portability And Accountability Act of 1996 (HIPAA).

Health Advantage Not Required to Agree

I understand that Arkansas Blue Cross and Blue Shield is not required to agree to this restriction.

Termination of Restriction

I understand that if Arkansas Blue Cross and Blue Shield agrees to this restriction, either Arkansas Blue Cross and Blue Shield or I may terminate this restriction at any time. The termination of the restriction is only effective for future uses and disclosures.

Emergency Treatment Exception

I understand that if protected health information must be used or disclosed to provide emergency treatment for me, then this restriction is void.

Questionnaire

Please complete all of the following questions. If the question is not applicable, mark N/A on the answer line.

☐ Restriction ☐ Discontinue restriction

(1) I request the following information (description of information)be restricted/ released from restriction:

(2) I request that use and disclosure of the above described information be restricted in the following manner (description of restriction):

(3) I request that my protected health information not be disclosed to the following individuals or entities (List individuals or entities to which information would not be disclosed):

I understand that if a restriction is not specifically listed above and agreed to in writing by the group health plan, it will not be effective.

Termination of restriction

☐ I request that the restriction described above be removed and all information available for treatment, payment, and health care operations.

Name

Street or PO box	**City**	**State**	**ZIP**

Member Identification Number

Do you participate in the Federal Employee Program?

☐ Yes ☐ No

Signature

Date signed (mm/dd/yyyy)

Please return this signed form to:
Privacy Office
P.O. Box 3216
Little Rock, AR 72203