# *SEAFARERS HEALTH AND BENEFITS PLAN*

5201 Auth Way
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 # xxx-xx-_____

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