



RESTRICTION REQUEST

Purpose: This form is used for an individual's request to restrict our use or disclosure of protected health information for treatment, payment or health care operations, or to persons involved in the individual's care or payment for that care.

SECTION A: Individual requesting restriction.

The Member's Information: Insert information about the individual requesting restriction.

Member Name: _____ Member ID Number: _____
Member Address: _____ Member Date of Birth: _____
Member Social Security No.: _____
Member Phone Number: _____ Member e-Mail: _____

SECTION B: To the individual—please read the following and complete the information requested.

You have the right to request that we restrict our use or disclosure of your protected health information for treatment, payment or health care operations or to persons involved in your care or payment for that care. We are under no obligation to agree to your request. If we do, our agreement must be in writing and we will then restrict our use or disclosure of your protected health information as you request. We may, notwithstanding our agreement, use or disclose the restricted information needed for your treatment in an appropriate medical emergency, or when the use or disclosure without your written permission is authorized or required by law.

You may end the restriction at any time by notifying us in writing. We may end our agreement to restrict use or disclosure of your protected health information at any time by notifying you in writing. If you agree with our decision to end the restriction, your protected health information will no longer be subject to the restriction. If you disagree, our termination of the restriction will apply only to your protected health information that we create or receive after we gave you our notice terminating the restriction.

The following information generated by BlueCross BlueShield of Tennessee is subject to a restriction request:

- Explanation of Benefits (EOB)
• Written Correspondence (i.e. letters)
• Telephone Inquiries

Please state the restriction you want to apply to that protected health information:

INDIVIDUAL'S SIGNATURE.

I request that you restrict the use or disclosure of my protected health information as specified in Section B above. I understand that you are under no obligation to agree to my request, and that there will be no agreement unless you inform me in writing that you agree to my request.

Signature: _____ Date: _____

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____
Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS REQUEST

Please return completed form to:

BlueCross BlueShield of Tennessee
Privacy Office
1 Cameron Hill Circle
Chattanooga TN 37402