REQUEST TO RESTRICT USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

I, ______________________________ (Insert Covered Individual's Name) hereby request that the following restriction(s) be placed on the uses and disclosures of my protected health information (PHI) by MedBen:

Please provide below a complete and specific description of the type of restrictions you are requesting regarding how and to whom your protected health information is used and disclosed. Restrictions may only be requested for those uses and disclosures that relate to your treatment, the payment of your health care coverage, the health care operations of the Group Health Plan listed above, or the business operations of MedBen and/or the Covered Individual's Group Health Plan.

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I understand that neither MedBen or the Group Health Plan is not required to agree to my restriction requests, but is only required to attempt to accommodate reasonable requests when appropriate. I further understand that both MedBen and the Group Health Plan reserve the right to terminate an agreed-to restriction if it feels that termination is appropriate, and that I also have the right to terminate, in writing, any restriction by sending a termination notice to MedBen Chief Privacy Officer.

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Print Name of Covered Individual

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Covered Individual's Signature & Date Signed

If you are a **Covered Individual's representative**, provide documentation or explanation of your authority to act for the Covered Individual and sign below.

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1975 Tamarack Road • Newark, OH 43055 • phone (800) 423-3151 • fax (740) 522-5002

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Print Name of Representative

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Covered Individual's Representative's Signature & Date Signed

No access request will be processed unless the Covered Individual or the Covered Individual's representative have signed this form.