

## Duke University Health Plan Participant's Request For Restrictions On Use and/or Disclosure of PHI

**Please complete this form and return it to the Benefits Administration and Communication Manager, Duke University Benefits Office, 2024 W. Main St., Durham, NC 27705 or fax it to (919) 681-8774.**

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

Home Telephone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Participant Identification Number and/or Social Security Number: \_\_\_\_\_

I, \_\_\_\_\_, am requesting a restriction on the Health Plan's use and/or disclosure of my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) in the manner described below. I understand that the Health Plan may deny this request for any reason. I also understand that if agreed to, the Health Plan may not be able to honor this request if I require emergency treatment and that the Health Plan may remove this restriction in the future, if I am notified in advance.

Description of Restriction of the Health Information to be Used or Disclosed. The following is a description of the specific health information I wish to restrict:

\_\_\_\_\_

Persons/Organizations Restricted from Use and/or Disclosure of Health Information. I request that the following person(s) and/or organization(s) not be allowed to use, receive and/or disclose the health information described above.

\_\_\_\_\_

By signing this form, I am confirming that it accurately reflects my wishes.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature Date

If signed by personal representative:

Name of personal representative: \_\_\_\_\_

Relationship to participant or nature of authority: \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Personal Representative Date