Request for Restriction of Protected Health Information

I hereby request restriction on the use and disclosure of my protected health information for treatment, payment, and health plan operations. I understand your organization is not required to agree to this restriction.

I understand that if the request for restriction is honored, your organization will document the request and maintain it for a minimum of six (6) years. Our organization is required to abide by the request except in case of an emergency. I understand this restriction will remain in effect until I request termination of the restriction or until your organization notifies me that it is terminating the restriction.

Please describe the personal and health information to be restricted:

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Please print the following information:

Name:______________________________ Date of Birth: ______________________

Daytime Phone: ______________________________

Alternate Phone:______________________________

Address: ______________________________

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Signature: ______________________________ Date: ______________________

Signature of Legal Representative

Only if individual is incompetent*: ______________________________ Date: ______________________

If signed by Legal Representative, relationship to individual: ______________________________

***If signed by Legal Representative, must provide representative documentation as required by state law, i.e., Health Care Power of Attorney, Health Care Surrogate, Living Will or Guardianship papers.**

To prevent a delay in fulfilling your request, please verify that all fields on the form are accurately completed. If information is missing, the form will be returned to you for completion.

Please attach a separate sheet if additional space is needed.

Please send this form to:
Harris, Rothenberg International, Inc. dba Humana EAP and Work Life Services,
100 William St., 10th Floor
New York, NY 10038

This organization follows the more stringent of all federal and state laws and regulations.