



Individual Request to Not Use or Disclose Health Information

I understand that the Lake County Board of County Commissioners Self-insured Group Health Plan may use and disclose protected health information about me for purposes of health care treatment, payment and health care operations without my consent. I request to restrict use and disclosure of protected health information concerning health care treatment, payment or health care operations about me by the Lake County Board of County Commissioners Self-insured Group Health Plan in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Group Health Plan Not Required to Agree

I understand that the group health plan is not required to agree to this restriction.

Termination of Restriction

I understand that if the group health plan agrees to this restriction, either the Plan or I may terminate this restriction at any time. The termination of the restriction is only effective for future uses and disclosures.

Emergency Treatment Exception

I understand that if protected health information must be used or disclosed to provide emergency treatment for me, then this restriction is void.

Questionnaire

Requestor: Please complete all of the following questions. If the question is not applicable, mark N/A on the answer line.

(1) I request the following information be restricted [description of information]:

(2) I request that use and disclosure of the above-described information be restricted in the following manner [description of restriction]:

(3) I request that my protected health information not be disclosed to the following individuals or entities [list individuals or entities to which information would not be disclosed]:

I understand that if a restriction is not specifically listed above and agreed to in writing by the group health plan, it will not be effective.

Printed name _____

Signature: _____ Date: _____