

IDAHO PIPE TRADES TRUST

REQUEST FOR RESTRICTIONS ON THE USE AND/OR DISCLOSURE OF PHI

Name of individual making request: _____ Birth Date: ____/____/____
MM / DD / YR

Address: _____

Home Telephone Number: _____ E-mail: _____
Participant Identification Number and/or Last 4 digits of Social Security Number: _____

I, _____, am requesting that the above Trust restrict the use and/or disclosure of my protected health information in the manner described below. I understand that the Trust may deny this request for any reason. I also understand that if agreed to, the Trust may not be able to honor this request if I require emergency treatment and that the Trust may remove this restriction in the future, if I am notified in advance. I also understand that if agreed to, it will not restrict or prevent uses or disclosures required by the Secretary of the US Dept of Health and Human Services to investigate the Trust's compliance with HIPAA or other uses or disclosures required by law.

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 (provide copy of document evidencing authority):

Name of personal representative: _____

Relationship to participant or nature of authority: _____

_____/____/____
Signature of Personal Representative Date